S. HRG. 106–491, PT. 3

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

ON

S. 2526

TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO REVISE AND EXTEND SUCH ACT

JULY 26, 2000
WASHINGTON, DC

PART 3

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CONTENTS

APPENDIX

REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

WEDNESDAY, JULY 26, 2000

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to other business, at 2:11 p.m. in room 485, Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senators Campbell, Inouye, and Dorgan.

STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. I will submit my complete opening statement for the record on S. 2526, since we have a short amount of time.

[Text of S. 2526 follows:]

II

106TH CONGRESS
2D SESSION

S. 2526

To amend the Indian Health Care Improvement Act to revise and extend such Act.

IN THE SENATE OF THE UNITED STATES

MAY 9, 2000

Mr. CAMPBELL (for himself and for Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

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A BILL

To amend the Indian Health Care Improvement Act to revise and extend such Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Indian Health Care Improvement Act Reauthorization of 2000".

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

TITLE I—REAUTHORIZATION AND REVISIONS OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

SEC. 101. AMENDMENT TO THE INDIAN HEALTH CARE IMPROVEMENT ACT.

The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended to read as follows:

"SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

"(a) SHORT TITLE.—This Act may be cited as the 'Indian Health Care Improvement Act'.

"(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

"SEC. 2. FINDINGS.

"Congress makes the following findings:

"(1) Federal delivery of health services and funding of tribal and urban Indian health programs to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with the American Indian people, as reflected in the Constitution, treaties, Federal laws, and the course

of dealings of the United States with Indian Tribes, and the United States' resulting government to government and trust responsibility and obligations to the American Indian people.

"(2) From the time of European occupation and colonization through the 20th century, the policies and practices of the United States caused or contributed to the severe health conditions of Indians.

"(3) Indian Tribes have, through the cession of over 400,000,000 acres of land to the United States in exchange for promises, often reflected in treaties, of health care secured a de facto contract that entitles Indians to health care in perpetuity, based on the moral, legal, and historic obligation of the United States.

"(4) The population growth of the Indian people that began in the later part of the 20th century increases the need for Federal health care services.

"(5) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians, regardless of where they live, to be raised to the highest possible level, a level that is not less than that of the general population, and to provide for the

maximum participation of Indian Tribes, tribal organizations, and urban Indian organizations in the planning, delivery, and management of those services.

"(6) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of illnesses among, and unnecessary and premature deaths of, Indians.

"(7) Despite such services, the unmet health needs of the American Indian people remain alarmingly severe, and even continue to increase, and the health status of the Indians is far below the health status of the general population of the United States.

"(8) The disparity in health status that is to be addresses is formidable. In death rates for example, Indian people suffer a death rate for diabetes mellitus that is 249 percent higher than the death rate for all races in the United States, a pneumonia and influenza death rate that is 71 percent higher, a tuberculosis death rate that is 533 percent higher, and a death rate from alcoholism that is 627 percent higher.

"SEC. 3. DECLARATION OF HEALTH OBJECTIVES.

"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people—

"(1) to assure the highest possible health status for Indians and to provide all resources necessary to effect that policy;

"(2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto;

"(3) in order to raise the health status of Indian people to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto, to permit Indian Tribes and tribal organizations to set their own health care priorities and establish goals that reflect their unmet needs;

"(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each geographic service area is raised to at least the level of that of the general population;

"(5) to require meaningful, active consultation with Indian Tribes, Indian organizations, and urban Indian organizations to implement this Act and the national policy of Indian self-determination; and

"(6) that funds for health care programs and facilities operated by Tribes and tribal organizations be provided in amounts that are not less than the funds that are provided to programs and facilities operated directly by the Service.

"SEC. 4. DEFINITIONS.

"In this Act:

"(1) ACCREDITED AND ACCESSIBLE.—The term 'accredited and accessible', with respect to an entity, means a community college or other appropriate entity that is on or near a reservation and accredited by a national or regional organization with accrediting authority.

"(2) AREA OFFICE.—The term 'area office' mean an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

"(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary of the Indian Health as established under section 601.

"(4) CONTRACT HEALTH SERVICE.—The term 'contract health service' means a health service that is provided at the expense of the Service, Indian Tribe, or tribal organization by a public or private medical provider or hospital, other than a service funded under the Indian Self-Determination and Education Assistance Act or under this Act.

"(5) DEPARTMENT.—The term 'Department', unless specifically provided otherwise, means the Department of Health and Human Services.

"(6) FUND.—The terms 'fund' or 'funding' mean the transfer of monies from the Department to any eligible entity or individual under this Act by any legal means, including funding agreements, contracts, memoranda of understanding, Buy Indian Act contracts, or otherwise.

"(7) FUNDING AGREEMENT.—The term 'funding agreement' means any agreement to transfer funds for the planning, conduct, and administration of programs, functions, services and activities to Tribes and tribal organizations from the Secretary under the authority of the Indian Self-Determination and Education Assistance Act.

"(8) HEALTH PROFESSION.—The term 'health profession' means allopathic medicine, family medi-

cine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, and allied health professions, or any other health profession.

"(9) HEALTH PROMOTION; DISEASE PREVENTION.—The terms 'health promotion' and 'disease prevention' shall have the meanings given such terms in paragraphs (1) and (2) of section 203(c).

"(10) INDIAN.—The term 'Indian' and 'Indians' shall have meanings given such terms for purposes of the Indian Self-Determination and Education Assistance Act.

"(11) INDIAN HEALTH PROGRAM.—The term 'Indian health program' shall have the meaning given such term in section 110(a)(2)(A).

"(12) INDIAN TRIBE.—The term 'Indian tribe' shall have the meaning given such term in section 4(e) of the Indian Self Determination and Education Assistance Act.

"(13) RESERVATION.—The term 'reservation' means any Federally recognized Indian tribe's res-

ervation, Pueblo or colony, including former reservations in Oklahoma, Alaska Native Regions established pursuant to the Alaska Native Claims Settlement Act, and Indian allotments.

"(14) SECRETARY.—The term 'Secretary', unless specifically provided otherwise, means the Secretary of Health and Human Services.

"(15) SERVICE.—The term 'Service' means the Indian Health Service.

"(16) SERVICE AREA.—The term 'service area' means the geographical area served by each area office.

"(17) SERVICE UNIT.—The term 'service unit' means—

"(A) an administrative entity within the Indian Health Service; or

"(B) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

"(18) TRADITIONAL HEALTH CARE PRACTICES.—The term 'traditional health care practices'

means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to western healing sciences) which embodies the influences or forces of innate tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which calls upon these influences or forces, including physical, mental, and spiritual forces in the promotion, restoration, preservation and maintenance of health, well-being, and life's harmony.

"(19) TRIBAL ORGANIZATION.—The term 'tribal organization' shall have the meaning given such term in section 4(l) of the Indian Self Determination and Education Assistance Act.

"(20) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' shall have the meaning given such term in section 126 (g)(2).

"(21) URBAN CENTER.—The term 'urban center' means any community that has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

"(22) URBAN INDIAN.—The term 'urban Indian' means any individual who resides in an urban center and who—

"(A) regardless of whether such individual lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940;

"(B) is an Eskimo or Aleut or other Alaskan Native;

"(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

"(D) is determined to be an Indian under regulations promulgated by the Secretary.

"(23) URBAN INDIAN ORGANIZATION.—The term 'urban Indian organization' means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the participation of all interested Indian groups and individuals, and which is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES AND DEVELOPMENT

"SEC. 101. PURPOSE.

"The purpose of this title is to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Service, Indian tribes, tribal organizations, and urban Indian organizations involved in the provision of health services to Indian people.

"SEC. 102. GENERAL REQUIREMENTS.

"(a) SERVICE AREA PRIORITIES.—Unless specifically provided otherwise, amounts appropriated for each fiscal year to carry out each program authorized under this title shall be allocated by the Secretary to the area office of each service area using a formula—

"(1) to be developed in consultation with Indian Tribes, tribal organizations and urban Indian organizations; and

"(2) that takes into account the human resource and development needs in each such service area.

"(b) CONSULTATION.—Each area office receiving funds under this title shall actively and continuously con-

sult with representatives of Indian tribes, tribal organizations, and urban Indian organizations to prioritize the utilization of funds provided under this title within the service area.

"(c) REALLOCATION.—Unless specifically prohibited, an area office may reallocate funds provided to the office under this title among the programs authorized by this title, except that scholarship and loan repayment funds shall not be used for administrative functions or expenses.

"(d) LIMITATION.—This section shall not apply with respect to individual recipients of scholarships, loans or other funds provided under this title (as this title existed 1 day prior to the date of enactment of this Act) until such time as the individual completes the course of study that is supported through the use of such funds.

"SEC. 103. HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall make funds available through the area office to public or nonprofit private health entities, or Indian tribes or tribal organizations to assist such entities in meeting the costs of—

"(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them—

"(A) to enroll in courses of study in such health professions; or

"(B) if they are not qualified to enroll in any such courses of study, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

"(2) publicizing existing sources of financial aid available to Indians enrolled in any course of study referred to in paragraph (1) or who are undertaking training necessary to qualify them to enroll in any such course of study; or

"(3) establishing other programs which the area office determines will enhance and facilitate the enrollment of Indians in, and the subsequent pursuit and completion by them of, courses of study referred to in paragraph (1).

"(b) ADMINISTRATIVE PROVISIONS.—

"(1) APPLICATION.—To be eligible to receive funds under this section an entity described in subsection (a) shall submit to the Secretary, through the appropriate area office, and have approved, an application in such form, submitted in such manner, and containing such information as the Secretary shall by regulation prescribe.

"(2) PREFERENCE.—In awarding funds under this section, the area office shall give a preference to applications submitted by Indian tribes, tribal organizations, or urban Indian organizations.

"(3) AMOUNT.—The amount of funds to be provided to an eligible entity under this section shall be determined by the area office. Payments under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as provided for in regulations promulgated pursuant to this Act.

"(4) TERMS.—A funding commitment under this section shall, to the extent not otherwise prohibited by law, be for a term of 3 years, as provided for in regulations promulgated pursuant to this Act.

"(c) DEFINITION.—For purposes of this section and sections 104 and 105, the terms 'Indian' and 'Indians' shall, in addition to the definition provided for in section 4, mean any individual who—

"(1) irrespective of whether such individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940;

"(2) is an Eskimo or Aleut or other Alaska Native;

"(3) is considered by the Secretary of the Interior to be an Indian for any purpose; or

"(4) is determined to be an Indian under regulations promulgated by the Secretary.

"SEC. 104. HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide scholarships through the area offices to Indians who—

"(1) have successfully completed their high school education or high school equivalency; and

"(2) have demonstrated the capability to successfully complete courses of study in the health professions.

"(b) PURPOSE.—Scholarships provided under this section shall be for the following purposes:

"(1) Compensatory preprofessional education of any recipient. Such scholarship shall not exceed 2 years on a full-time basis (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act).

"(2) Pregraduate education of any recipient leading to a baccalaureate degree in an approved

course of study preparatory to a field of study in a health profession, such scholarship not to exceed 4 years (or the part-time equivalent thereof, as determined by the area office pursuant to regulations promulgated under this Act) except that an extension of up to 2 years may be approved by the Secretary.

"(c) USE OF SCHOLARSHIP.—Scholarships made under this section may be used to cover costs of tuition, books, transportation, board, and other necessary related expenses of a recipient while attending school.

"(d) LIMITATIONS.—Scholarship assistance to an eligible applicant under this section shall not be denied solely on the basis of—

"(1) the applicant's scholastic achievement if such applicant has been admitted to, or maintained good standing at, an accredited institution; or

"(2) the applicant's eligibility for assistance or benefits under any other Federal program.

"SEC. 105. INDIAN HEALTH PROFESSIONS SCHOLARSHIPS.

"(a) SCHOLARSHIPS.—

"(1) IN GENERAL.—In order to meet the needs of Indians, Indian tribes, tribal organizations, and urban Indian organizations for health professionals, the Secretary, acting through the Service and in ac-

cordance with this section, shall provide scholarships through the area offices to Indians who are enrolled full or part time in accredited schools and pursuing courses of study in the health professions. Such scholarships shall be designated Indian Health Scholarships and shall, except as provided in subsection (b), be made in accordance with section 338A of the Public Health Service Act (42 U.S.C. 254l).

"(2) NO DELEGATION.—The Director of the Service shall administer this section and shall not delegate any administrative functions under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act.

"(b) ELIGIBILITY.—

"(1) ENROLLMENT.—An Indian shall be eligible for a scholarship under subsection (a) in any year in which such individual is enrolled full or part time in a course of study referred to in subsection (a)(1).

"(2) SERVICE OBLIGATION.—

"(A) PUBLIC HEALTH SERVICE ACT.—The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 254l) that an Indian has entered into under

that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice on an equivalent year for year obligation, by service—

"(i) in the Indian Health Service;

"(ii) in a program conducted under a funding agreement entered into under the Indian Self-Determination and Education Assistance Act;

"(iii) in a program assisted under title V; or

"(iv) in the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"(B) DEFERRING ACTIVE SERVICE.—At the request of any Indian who has entered into a contract referred to in subparagraph (A) and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary

shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:

"(i) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service that is required under this section.

"(ii) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).

"(iii) The active duty service obligation will be served in the health profession of that individual, in a manner consistent with clauses (i) through (iv) of subparagraph (A).

"(C) NEW SCHOLARSHIP RECIPIENTS.—A recipient of an Indian Health Scholarship that

is awarded after December 31, 2001, shall meet the active duty service obligation under such scholarship by providing service within the service area from which the scholarship was awarded. In placing the recipient for active duty the area office shall give priority to the program that funded the recipient, except that in cases of special circumstances, a recipient may be placed in a different service area pursuant to an agreement between the areas or programs involved.

"(D) PRIORITY IN ASSIGNMENT.—Subject to subparagraph (C), the area office, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation described in subparagraph (A), shall give priority to assigning individuals to service in those programs specified in subparagraph (A) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

"(3) PART-TIME ENROLLMENT.—In the case of an Indian receiving a scholarship under this section

who is enrolled part time in an approved course of study—

"(A) such scholarship shall be for a period of years not to exceed the part-time equivalent of 4 years, as determined by the appropriate area office;

"(B) the period of obligated service described in paragraph (2)(A) shall be equal to the greater of—

"(i) the part-time equivalent of 1 year for each year for which the individual was provided a scholarship (as determined by the area office); or

"(ii) two years; and

"(C) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254l(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

"(4) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An Indian who has, on or after the date of the enactment of this paragraph, entered into a written contract with

the area office pursuant to a scholarship under this section and who—

"(i) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

"(ii) is dismissed from such educational institution for disciplinary reasons;

"(iii) voluntarily terminates the training in such an educational institution for which he or she is provided a scholarship under such contract before the completion of such training; or

"(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract;

in lieu of any service obligation arising under such contract, shall be liable to the United States for the amount which has been paid to him or her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A) an individual breaches his or her written contract by failing either to begin such individual's service obligation under this section or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"(C) DEATH.—Upon the death of an individual who receives an Indian Health Scholarship, any obligation of that individual for service or payment that relates to that scholarship shall be canceled.

"(D) WAIVER.—The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary, in consultation with the appropriate area office, Indian tribe, tribal organization, and urban Indian organization, determines that—

"(i) it is not possible for the recipient to meet that obligation or make that payment;

"(ii) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

"(iii) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

"(E) HARDSHIP OR GOOD CAUSE.—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

"(F) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds

that the nondischarge of the obligation would be unconscionable.

"(c) FUNDING FOR TRIBES FOR SCHOLARSHIP PROGRAMS.—

"(1) PROVISION OF FUNDS.—

"(A) IN GENERAL.—The Secretary shall make funds available, through area offices, to Indian Tribes and tribal organizations for the purpose of assisting such Tribes and tribal organizations in educating Indians to serve as health professionals in Indian communities.

"(B) LIMITATION.—The Secretary shall ensure that amounts available for grants under subparagraph (A) for any fiscal year shall not exceed an amount equal to 5 percent of the amount available for each fiscal year for Indian Health Scholarships under this section.

"(C) APPLICATION.—An application for funds under subparagraph (A) shall be in such form and contain such agreements, assurances and information as consistent with this section.

"(2) REQUIREMENTS.—

"(A) IN GENERAL.—An Indian Tribe or tribal organization receiving funds under paragraph (1) shall agree to provide scholarships to

Indians in accordance with the requirements of this subsection.

"(B) MATCHING REQUIREMENT.—With respect to the costs of providing any scholarship pursuant to subparagraph (A)—

"(i) 80 percent of the costs of the scholarship shall be paid from the funds provided under paragraph (1) to the Indian Tribe or tribal organization; and

"(ii) 20 percent of such costs shall be paid from any other source of funds.

"(3) ELIGIBILITY.—An Indian Tribe or tribal organization shall provide scholarships under this subsection only to Indians who are enrolled or accepted for enrollment in a course of study (approved by the Secretary) in one of the health professions described in this Act.

"(4) CONTRACTS.—In providing scholarships under paragraph (1), the Secretary and the Indian Tribe or tribal organization shall enter into a written contract with each recipient of such scholarship. Such contract shall—

"(A) obligate such recipient to provide service in an Indian health program (as defined in section 110(a)(2)(A)) in the same service

area where the Indian Tribe or tribal organization providing the scholarship is located, for—

"(i) a number of years equal to the number of years for which the scholarship is provided (or the part-time equivalent thereof, as determined by the Secretary), or for a period of 2 years, whichever period is greater; or

"(ii) such greater period of time as the recipient and the Indian Tribe or tribal organization may agree;

"(B) provide that the scholarship—

"(i) may only be expended for—

"(I) tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in attendance at the educational institution; and

"(II) payment to the recipient of a monthly stipend of not more than the amount authorized by section 338(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254m(g)(1)(B), such amount to be reduced pro rata (as determined by the

Secretary) based on the number of hours such student is enrolled, and may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

"(ii) may not exceed, for any year of attendance which the scholarship is provided, the total amount required for the year for the purposes authorized in clause (i);

"(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

"(D) require the recipient of such scholarship to meet the educational and licensure requirements appropriate to the health profession involved.

"(5) BREACH OF CONTRACT.—

"(A) IN GENERAL.—An individual who has entered into a written contract with the Sec-

retary and an Indian Tribe or tribal organization under this subsection and who—

"(i) fails to maintain an acceptable level of academic standing in the education institution in which he or she is enrolled (such level determined by the educational institution under regulations of the Secretary);

"(ii) is dismissed from such education for disciplinary reasons;

"(iii) voluntarily terminates the training in such an educational institution for which he or she has been provided a scholarship under such contract before the completion of such training; or

"(iv) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract;

shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract.

"(B) FAILURE TO PERFORM SERVICE OBLIGATION.—If for any reason not specified in subparagraph (A), an individual breaches his or her written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"(C) INFORMATION.—The Secretary may carry out this subsection on the basis of information received from Indian Tribes or tribal organizations involved, or on the basis of information collected through such other means as the Secretary deems appropriate.

"(6) REQUIRED AGREEMENTS.—The recipient of a scholarship under paragraph (1) shall agree, in providing health care pursuant to the requirements of this subsection—

"(A) not to discriminate against an individual seeking care on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made

pursuant to the program established in title XVIII of the Social Security Act or pursuant to the programs established in title XIX of such Act; and

"(B) to accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under part B of title XVIII of such Act, and to enter into an appropriate agreement with the State agency that administers the State plan for medical assistance under title XIX of such Act to provide service to individuals entitled to medical assistance under the plan.

"(7) PAYMENTS.—The Secretary, through the area office, shall make payments under this subsection to an Indian Tribe or tribal organization for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary or area office determines that, for the immediately preceding fiscal year, the Indian Tribe or tribal organization has not complied with the requirements of this subsection.

"SEC. 106. AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.

"(a) IN GENERAL.—Notwithstanding section 102, the Secretary shall provide funds to at least 3 colleges and

universities for the purpose of developing and maintaining American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental health field. These programs shall be located at various colleges and universities throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

"(b) QUENTIN N. BURDICK AMERICAN INDIANS INTO PSYCHOLOGY PROGRAM.—The Secretary shall provide funds under subsection (a) to develop and maintain a program at the University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Psychology Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Nursing Program authorized under section 115, the Quentin N. Burdick Indians into Health Program authorized under section 117, and existing university research and communications networks.

"(c) REQUIREMENTS.—

"(1) REGULATIONS.—The Secretary shall promulgate regulations pursuant to this Act for the competitive awarding of funds under this section.

"(2) PROGRAM.—Applicants for funds under this section shall agree to provide a program which, at a minimum—

"(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and accredited and accessible community colleges that will be served by the program;

"(B) incorporates a program advisory board comprised of representatives from the Tribes and communities that will be served by the program;

"(C) provides summer enrichment programs to expose Indian students to the various fields of psychology through research, clinical, and experimental activities;

"(D) provides stipends to undergraduate and graduate students to pursue a career in psychology;

"(E) develops affiliation agreements with tribal community colleges, the Service, university affiliated programs, and other appropriate accredited and accessible entities to enhance the education of Indian students;

"(F) utilizes, to the maximum extent feasible, existing university tutoring, counseling and student support services; and

"(G) employs, to the maximum extent feasible, qualified Indians in the program.

"(d) ACTIVE DUTY OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each graduate who receives a stipend described in subsection (c)(2)(C) that is funded under this section. Such obligation shall be met by service—

"(1) in the Indian Health Service;

"(2) in a program conducted under a funding agreement contract entered into under the Indian Self-Determination and Education Assistance Act;

"(3) in a program assisted under title V; or

"(4) in the private practice of psychology if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"SEC. 107. INDIAN HEALTH SERVICE EXTERN PROGRAMS.

"(a) IN GENERAL.—Any individual who receives a scholarship pursuant to section 105 shall be entitled to

employment in the Service, or may be employed by a program of an Indian tribe, tribal organization, or urban Indian organization, or other agency of the Department as may be appropriate and available, during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship.

"(b) ENROLLEES IN COURSE OF STUDY.—Any individual who is enrolled in a course of study in the health professions may be employed by the Service or by an Indian tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(c) HIGH SCHOOL PROGRAMS.—Any individual who is in a high school program authorized under section 103(a) may be employed by the Service, or by a Indian Tribe, tribal organization, or urban Indian organization, during any nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

"(d) ADMINISTRATIVE PROVISIONS.—Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency per-

sonnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department.

"SEC. 108. CONTINUING EDUCATION ALLOWANCES.

"In order to encourage health professionals, including for purposes of this section, community health representatives and emergency medical technicians, to join or continue in the Service or in any program of an Indian tribe, tribal organization, or urban Indian organization and to provide their services in the rural and remote areas where a significant portion of the Indian people reside, the Secretary, acting through the area offices, may provide allowances to health professionals employed in the Service or such a program to enable such professionals to take leave of their duty stations for a period of time each year (as prescribed by regulations of the Secretary) for professional consultation and refresher training courses.

"SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall maintain a Community Health Representative Program under which the Service, Indian tribes and tribal organizations—

"(1) provide for the training of Indians as community health representatives; and

"(2) use such community health representatives in the provision of health care, health promotion, and disease prevention services to Indian communities.

"(b) ACTIVITIES.—The Secretary, acting through the Community Health Representative Program, shall—

"(1) provide a high standard of training for community health representatives to ensure that the community health representatives provide quality health care, health promotion, and disease prevention services to the Indian communities served by such Program;

"(2) in order to provide such training, develop and maintain a curriculum that—

"(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

"(B) provides instruction and practical experience in health promotion and disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

"(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and maintain programs that meet the needs for such continuing education;

"(4) maintain a system that provides close supervision of community health representatives;

"(5) maintain a system under which the work of community health representatives is reviewed and evaluated; and

"(6) promote traditional health care practices of the Indian tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

"SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall establish a program to be

known as the Indian Health Service Loan Repayment Program (referred to in this Act as the 'Loan Repayment Program') in order to assure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

"(2) DEFINITIONS.—In this section:

"(A) INDIAN HEALTH PROGRAM.—The term 'Indian health program' means any health program or facility funded, in whole or part, by the Service for the benefit of Indians and administered—

"(i) directly by the Service;

"(ii) by any Indian tribe or tribal or Indian organization pursuant to a funding agreement under—

"(I) the Indian Self-Determination and Educational Assistance Act; or

"(II) section 23 of the Act of April 30, 1908 (25 U.S.C. 47) (commonly known as the 'Buy-Indian Act'); or

"(iii) by an urban Indian organization pursuant to title V.

"(B) STATE.—The term 'State' has the same meaning given such term in section 331(i)(4) of the Public Health Service Act.

"(b) ELIGIBILITY.—To be eligible to participate in the Loan Repayment Program, an individual must—

"(1)(A) be enrolled—

"(i) in a course of study or program in an accredited institution, as determined by the Secretary, within any State and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

"(ii) in an approved graduate training program in a health profession; or

"(B) have—

"(i) a degree in a health profession; and

"(ii) a license to practice a health profession in a State;

"(2)(A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;

"(B) be eligible for selection for civilian service in the Regular or Reserve Corps of the Public Health Service;

"(C) meet the professional standards for civil service employment in the Indian Health Service; or

"(D) be employed in an Indian health program without a service obligation; and

"(3) submit to the Secretary an application for a contract described in subsection (f).

"(c) FORMS.—

"(1) IN GENERAL.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (l) in the case of the individual's breach of the contract. The Secretary shall provide such individuals with sufficient information regarding the advantages and disadvantages of service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or a civilian employee of the Indian Health

Service to enable the individual to make a decision on an informed basis.

"(2) FORMS TO BE UNDERSTANDABLE.—The application form, contract form, and all other information furnished by the Secretary under this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program.

"(3) AVAILABILITY.—The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.

"(d) PRIORITY.—

"(1) ANNUAL DETERMINATIONS.—The Secretary, acting through the Service and in accordance with subsection (k), shall annually—

"(A) identify the positions in each Indian health program for which there is a need or a vacancy; and

"(B) rank those positions in order of priority.

"(2) PRIORITY IN APPROVAL.—Consistent with the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall give priority to applications made by—

"(A) Indians; and

"(B) individuals recruited through the efforts an Indian tribe, tribal organization, or urban Indian organization.

"(e) CONTRACTS.—

"(1) IN GENERAL.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in subsection (f).

"(2) NOTICE.—Not later than 21 days after considering an individual for participation in the Loan Repayment Program under paragraph (1), the Secretary shall provide written notice to the individual of—

"(A) the Secretary's approving of the individual's participation in the Loan Repayment Program, including extensions resulting in an aggregate period of obligated service in excess of 4 years; or

"(B) the Secretary's disapproving an individual's participation in such Program.

"(f) WRITTEN CONTRACT.—The written contract referred to in this section between the Secretary and an individual shall contain—

"(1) an agreement under which—

"(A) subject to paragraph (3), the Secretary agrees—

"(i) to pay loans on behalf of the individual in accordance with the provisions of this section; and

"(ii) to accept (subject to the availability of appropriated funds for carrying out this section) the individual into the Service or place the individual with a tribe, tribal organization, or urban Indian organization as provided in subparagraph (B)(iii); and

"(B) subject to paragraph (3), the individual agrees—

"(i) to accept loan payments on behalf of the individual;

"(ii) in the case of an individual described in subsection (b)(1)—

"(I) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and

"(II) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training);

"(iii) to serve for a time period (referred to in this section as the 'period of obligated service') equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual's profession in an Indian health program to which the individual may be assigned by the Secretary;

"(2) a provision permitting the Secretary to extend for such longer additional periods, as the individual may agree to, the period of obligated service agreed to by the individual under paragraph (1)(B)(iii);

"(3) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;

"(4) a statement of the damages to which the United States is entitled under subsection (l) for the individual's breach of the contract; and

"(5) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

"(g) LOAN REPAYMENTS.—

"(1) IN GENERAL.—A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual regarding the undergraduate or graduate education of the individual (or both), which loans were made for—

"(A) tuition expenses;

"(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and

"(C) reasonable living expenses as determined by the Secretary.

"(2) AMOUNT OF PAYMENT.—

"(A) IN GENERAL.—For each year of obligated service that an individual contracts to serve under subsection (f) the Secretary may pay up to $35,000 (or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act) on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of such service by an individual, the Secretary shall consider the extent to which each such determination—

"(i) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

"(ii) provides an incentive to serve in Indian health programs with the greatest shortages of health professionals; and

"(iii) provides an incentive with respect to the health professional involved remaining in an Indian health program with such a health professional shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

"(B) TIME FOR PAYMENT.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made not later than the end of the fiscal year in which the individual completes such year of service.

"(3) SCHEDULE FOR PAYMENTS.—The Secretary may enter into an agreement with the holder of any loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

"(h) COUNTING OF INDIVIDUALS.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic training, shall not be

counted against any employment ceiling affecting the Department.

"(i) RECRUITING PROGRAMS.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other health professional programs of the Service at educational institutions training health professionals or specialists identified in subsection (a).

"(j) NONAPPLICATION OF CERTAIN PROVISION.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

"(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian health programs pursuant to contracts entered into under this section, shall—

"(1) ensure that the staffing needs of Indian health programs administered by an Indian tribe or tribal or health organization receive consideration on an equal basis with programs that are administered directly by the Service; and

"(2) give priority to assigning individuals to Indian health programs that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

"(l) BREACH OF CONTRACT.—

"(1) IN GENERAL.—An individual who has entered into a written contract with the Secretary under this section and who—

"(A) is enrolled in the final year of a course of study and who—

"(i) fails to maintain an acceptable level of academic standing in the educational institution in which he is enrolled (such level determined by the educational institution under regulations of the Secretary);

"(ii) voluntarily terminates such enrollment; or

"(iii) is dismissed from such educational institution before completion of such course of study; or

"(B) is enrolled in a graduate training program, and who fails to complete such training program, and does not receive a waiver from the Secretary under subsection (b)(1)(B)(ii),

shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amount which has been paid on such individual's behalf under the contract.

"(2) AMOUNT OF RECOVERY.—If, for any reason not specified in paragraph (1), an individual breaches his written contract under this section by failing either to begin, or complete, such individual's period of obligated service in accordance with subsection (f), the United States shall be entitled to recover from such individual an amount to be determined in accordance with the following formula:

$$A=3Z(t-s/t)$$

in which—

"(A) 'A' is the amount the United States is entitled to recover;

"(B) 'Z' is the sum of the amounts paid under this section to, or on behalf of, the individual and the interest on such amounts which would be payable if, at the time the amounts were paid, they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States;

"(C) 't' is the total number of months in the individual's period of obligated service in accordance with subsection (f); and

"(D) 's' is the number of months of such period served by such individual in accordance with this section.

Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.

"(3) DAMAGES.—

"(A) TIME FOR PAYMENT.—Any amount of damages which the United States is entitled to recover under this subsection shall be paid to the United States within the 1-year period beginning on the date of the breach of contract or such longer period beginning on such date as shall be specified by the Secretary.

"(B) DELINQUENCIES.—If damages described in subparagraph (A) are delinquent for 3 months, the Secretary shall, for the purpose of recovering such damages—

"(i) utilize collection agencies contracted with by the Administrator of the General Services Administration; or

"(ii) enter into contracts for the recovery of such damages with collection agencies selected by the Secretary.

"(C) CONTRACTS FOR RECOVERY OF DAMAGES.—Each contract for recovering damages pursuant to this subsection shall provide that

the contractor will, not less than once each 6 months, submit to the Secretary a status report on the success of the contractor in collecting such damages. Section 3718 of title 31, United States Code, shall apply to any such contract to the extent not inconsistent with this subsection.

"(m) CANCELLATION, WAIVER OR RELEASE.—

"(1) CANCELLATION.—Any obligation of an individual under the Loan Repayment Program for service or payment of damages shall be canceled upon the death of the individual.

"(2) WAIVER OF SERVICE OBLIGATION.—The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

"(3) WAIVER OF RIGHTS OF UNITED STATES.—The Secretary may waive, in whole or in part, the rights of the United States to recover amounts under this section in any case of extreme hardship

or other good cause shown, as determined by the Secretary.

"(4) RELEASE.—Any obligation of an individual under the Loan Repayment Program for payment of damages may be released by a discharge in bankruptcy under title 11 of the United States Code only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required, and only if the bankruptcy court finds that nondischarge of the obligation would be unconscionable.

"(n) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be submitted to the Congress under section 801, a report concerning the previous fiscal year which sets forth—

"(1) the health professional positions maintained by the Service or by tribal or Indian organizations for which recruitment or retention is difficult;

"(2) the number of Loan Repayment Program applications filed with respect to each type of health profession;

"(3) the number of contracts described in subsection (f) that are entered into with respect to each health profession;

"(4) the amount of loan payments made under this section, in total and by health profession;

"(5) the number of scholarship grants that are provided under section 105 with respect to each health profession;

"(6) the amount of scholarship grants provided under section 105, in total and by health profession;

"(7) the number of providers of health care that will be needed by Indian health programs, by location and profession, during the 3 fiscal years beginning after the date the report is filed; and

"(8) the measures the Secretary plans to take to fill the health professional positions maintained by the Service or by tribes, tribal organizations, or urban Indian organizations for which recruitment or retention is difficult.

"SEC. 111. SCHOLARSHIP AND LOAN REPAYMENT RECOVERY FUND.

"(a) ESTABLISHMENT.—Notwithstanding section 102, there is established in the Treasury of the United States a fund to be known as the Indian Health Scholarship and Loan Repayment Recovery Fund (referred to in this section as the 'LRRF'). The LRRF Fund shall consist of—

"(1) such amounts as may be collected from individuals under subparagraphs (A) and (B) of section 105(b)(4) and section 110(l) for breach of contract;

"(2) such funds as may be appropriated to the LRRF;

"(3) such interest earned on amounts in the LRRF; and

"(4) such additional amounts as may be collected, appropriated, or earned relative to the LRRF.

Amounts appropriated to the LRRF shall remain available until expended.

"(b) USE OF LRRF.—

"(1) IN GENERAL.—Amounts in the LRRF may be expended by the Secretary, subject to section 102, acting through the Service, to make payments to the Service or to an Indian tribe or tribal organization administering a health care program pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act—

"(A) to which a scholarship recipient under section 105 or a loan repayment program participant under section 110 has been assigned to

meet the obligated service requirements pursuant to sections; and

"(B) that has a need for a health professional to provide health care services as a result of such recipient or participant having breached the contract entered into under section 105 or section 110.

"(2) SCHOLARSHIPS AND RECRUITING.—An Indian tribe or tribal organization receiving payments pursuant to paragraph (1) may expend the payments to provide scholarships or to recruit and employ, directly or by contract, health professionals to provide health care services.

"(c) INVESTING OF FUND.—

"(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the LRRF as the Secretary determines are not required to meet current withdrawals from the LRRF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

"(2) SALE PRICE.—Any obligation acquired by the LRRF may be sold by the Secretary of the Treasury at the market price.

"SEC. 112. RECRUITMENT ACTIVITIES.

"(a) REIMBURSEMENT OF EXPENSES.—The Secretary may reimburse health professionals seeking positions in the Service, Indian tribes, tribal organizations, or urban Indian organizations, including unpaid student volunteers and individuals considering entering into a contract under section 110, and their spouses, for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with respect to such assignment.

"(b) ASSIGNMENT OF PERSONNEL.—The Secretary, acting through the Service, shall assign one individual in each area office to be responsible on a full-time basis for recruitment activities.

"SEC. 113. TRIBAL RECRUITMENT AND RETENTION PROGRAM.

"(a) FUNDING OF PROJECTS.—The Secretary, acting through the Service, shall fund innovative projects for a period not to exceed 3 years to enable Indian tribes, tribal organizations, and urban Indian organizations to recruit, place, and retain health professionals to meet the staffing

needs of Indian health programs (as defined in section 110(a)(2)(A)).

"(b) ELIGIBILITY.—Any Indian tribe, tribal organization, or urban Indian organization may submit an application for funding of a project pursuant to this section.

"SEC. 114. ADVANCED TRAINING AND RESEARCH.

"(a) DEMONSTRATION PROJECT.—The Secretary, acting through the Service, shall establish a demonstration project to enable health professionals who have worked in an Indian health program (as defined in section 110) for a substantial period of time to pursue advanced training or research in areas of study for which the Secretary determines a need exists.

"(b) SERVICE OBLIGATION.—

"(1) IN GENERAL.—An individual who participates in the project under subsection (a), where the educational costs are borne by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to at least the period of time during which the individual participates in such project.

"(2) FAILURE TO COMPLETE SERVICE.—In the event that an individual fails to complete a period of obligated service under paragraph (1), the individual shall be liable to the United States for the period of

service remaining. In such event, with respect to individuals entering the project after the date of the enactment of this Act, the United States shall be entitled to recover from such individual an amount to be determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"(c) OPPORTUNITY TO PARTICIPATE.—Health professionals from Indian tribes, tribal organizations, and urban Indian organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to participate in the program under subsection (a).

"SEC. 115. NURSING PROGRAMS; QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.

"(a) GRANTS.—Notwithstanding section 102, the Secretary, acting through the Service, shall provide funds to—

"(1) public or private schools of nursing;

"(2) tribally controlled community colleges and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

"(3) nurse midwife programs, and advance practice nurse programs, that are provided by any tribal college accredited nursing program, or in the absence of such, any other public or private institution,

for the purpose of increasing the number of nurses, nurse midwives, and nurse practitioners who deliver health care services to Indians.

"(b) USE OF GRANTS.—Funds provided under subsection (a) may be used to—

"(1) recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses;

"(2) provide scholarships to Indian individuals enrolled in such programs that may be used to pay the tuition charged for such program and for other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses;

"(3) provide a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians;

"(4) provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses; or

"(5) provide any program that is designed to achieve the purpose described in subsection (a).

"(c) APPLICATIONS.—Each application for funds under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

"(d) PREFERENCES.—In providing funds under subsection (a), the Secretary shall extend a preference to—

"(1) programs that provide a preference to Indians;

"(2) programs that train nurse midwives or advanced practice nurses;

"(3) programs that are interdisciplinary; and

"(4) programs that are conducted in cooperation with a center for gifted and talented Indian students established under section 5324(a) of the Indian Education Act of 1988.

"(e) QUENTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.—The Secretary shall ensure that a portion of the funds authorized under subsection (a) is made available to establish and maintain a program at the

University of North Dakota to be known as the 'Quentin N. Burdick American Indians Into Nursing Program'. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick Indian Health Programs established under section 117(b).

"(f) SERVICE OBLIGATION.—The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assistance described in paragraph (1) or (2) of subsection (b) that is funded under subsection (a). Such obligation shall be met by service—

"(1) in the Indian Health Service;

"(2) in a program conducted under a contract entered into under the Indian Self-Determination and Education assistance Act;

"(3) in a program assisted under title V; or

"(4) in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"SEC. 116. TRIBAL CULTURE AND HISTORY.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian tribes in each service area receive educational instruction in the history and culture of such tribes and their relationship to the Service.

"(b) REQUIREMENTS.—To the extent feasible, the educational instruction to be provided under subsection (a) shall—

"(1) be provided in consultation with the affected tribal governments, tribal organizations, and urban Indian organizations;

"(2) be provided through tribally-controlled community colleges (within the meaning of section 2(4) of the Tribally Controlled Community College Assistance Act of 1978) and tribally controlled postsecondary vocational institutions (as defined in section 390(2) of the Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)); and

"(3) include instruction in Native American studies.

"SEC. 117. INMED PROGRAM.

"(a) GRANTS.—The Secretary may provide grants to 3 colleges and universities for the purpose of maintaining and expanding the Native American health careers recruit-

ment program known as the 'Indians into Medicine Program' (referred to in this section as 'INMED') as a means of encouraging Indians to enter the health professions.

"(b) QUENTIN N. BURDICK INDIAN HEALTH PROGRAM.—The Secretary shall provide 1 of the grants under subsection (a) to maintain the INMED program at the University of North Dakota, to be known as the 'Quentin N. Burdick Indian Health Program', unless the Secretary makes a determination, based upon program reviews, that the program is not meeting the purposes of this section. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick American Indians Into Psychology Program established under section 106(b) and the Quentin N. Burdick American Indians Into Nursing Program established under section 115.

"(c) REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall develop regulations to govern grants under to this section.

"(2) PROGRAM REQUIREMENTS.—Applicants for grants provided under this section shall agree to provide a program that—

"(A) provides outreach and recruitment for health professions to Indian communities including elementary, secondary and community

colleges located on Indian reservations which will be served by the program;

"(B) incorporates a program advisory board comprised of representatives from the tribes and communities which will be served by the program;

"(C) provides summer preparatory programs for Indian students who need enrichment in the subjects of math and science in order to pursue training in the health professions;

"(D) provides tutoring, counseling and support to students who are enrolled in a health career program of study at the respective college or university; and

"(E) to the maximum extent feasible, employs qualified Indians in the program.

"SEC. 118. HEALTH TRAINING PROGRAMS OF COMMUNITY COLLEGES.

"(a) ESTABLISHMENT GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges for the purpose of assisting such colleges in the establishment of programs which provide education in a health profession leading to a degree or diploma in a health pro-

fession for individuals who desire to practice such profession on an Indian reservation, in the Service, or in a tribal health program.

"(2) AMOUNT.—The amount of any grant awarded to a community college under paragraph (1) for the first year in which such a grant is provided to the community college shall not exceed $100,000.

"(b) CONTINUATION GRANTS.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall award grants to accredited and accessible community colleges that have established a program described in subsection (a)(1) for the purpose of maintaining the program and recruiting students for the program.

"(2) ELIGIBILITY.—Grants may only be made under this subsection to a community college that—

"(A) is accredited;

"(B) has a relationship with a hospital facility, Service facility, or hospital that could provide training of nurses or health professionals;

"(C) has entered into an agreement with an accredited college or university medical school, the terms of which—

"(i) provide a program that enhances the transition and recruitment of students into advanced baccalaureate or graduate programs which train health professionals; and

"(ii) stipulate certifications necessary to approve internship and field placement opportunities at health programs of the Service or at tribal health programs;

"(D) has a qualified staff which has the appropriate certifications;

"(E) is capable of obtaining State or regional accreditation of the program described in subsection (a)(1); and

"(F) agrees to provide for Indian preference for applicants for programs under this section.

"(c) SERVICE PERSONNEL AND TECHNICAL ASSISTANCE.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1) by—

"(1) entering into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs, and

"(2) providing technical assistance and support to such colleges.

"(d) SPECIFIED COURSES OF STUDY.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

"(1) has already received a degree or diploma in such health profession; and

"(2) provides clinical services on an Indian reservation, at a Service facility, or at a tribal clinic.

Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (b)(2)(C).

"(e) PRIORITY.—Priority shall be provided under this section to tribally controlled colleges in service areas that meet the requirements of subsection (b).

"(f) DEFINITIONS.—In this section:

"(1) COMMUNITY COLLEGE.—The term 'community college' means—

"(A) a tribally controlled community college; or

"(B) a junior or community college.

"(2) JUNIOR OR COMMUNITY COLLEGE.—The term 'junior or community college" has the meaning given such term by section 312(e) of the Higher Education Act of 1965 (20 U.S.C. 1058(e)).

"(3) TRIBALLY CONTROLLED COLLEGE.—The term 'tribally controlled college' has the meaning given the term 'tribally controlled community college' by section 2(4) of the Tribally Controlled Community College Assistance Act of 1978.

"SEC. 119. RETENTION BONUS.

"(a) IN GENERAL.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in, the Service, an Indian tribe, a tribal organization, or an urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

"(1) is assigned to, and serving in, a position for which recruitment or retention of personnel is difficult;

"(2) the Secretary determines is needed by the Service, tribe, tribal organization, or urban organization;

"(3) has—

"(A) completed 3 years of employment with the Service; tribe, tribal organization, or urban organization; or

"(B) completed any service obligations incurred as a requirement of—

"(i) any Federal scholarship program; or

"(ii) any Federal education loan repayment program; and

"(4) enters into an agreement with the Service, Indian tribe, tribal organization, or urban Indian organization for continued employment for a period of not less than 1 year.

"(b) RATES.—The Secretary may establish rates for the retention bonus which shall provide for a higher annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

"(c) FAILURE TO COMPLETE TERM OF SERVICE.—Any health professional failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as

determined by the Secretary in accordance with section 110(l)(2)(B).

"(d) FUNDING AGREEMENT.—The Secretary may pay a retention bonus to any health professional employed by an organization providing health care services to Indians pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act if such health professional is serving in a position which the Secretary determines is—

"(1) a position for which recruitment or retention is difficult; and

"(2) necessary for providing health care services to Indians.

"SEC. 120. NURSING RESIDENCY PROGRAM.

"(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian health program (as defined in section 110(a)(2)(A)), and have done so for a period of not less than 1 year, to pursue advanced training.

"(b) REQUIREMENT.—The program established under subsection (a) shall include a combination of education and work study in an Indian health program (as defined in section 110(a)(2)(A)) leading to an associate

or bachelor's degree (in the case of a licensed practical nurse or licensed vocational nurse) or a bachelor's degree (in the case of a registered nurse) or an advanced degrees in nursing and public health.

"(c) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian health program for a period of obligated service equal to the amount of time during which the individual participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula specified in subsection (l) of section 110 in the manner provided for in such subsection.

"SEC. 121. COMMUNITY HEALTH AIDE PROGRAM FOR ALASKA.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13; commonly known as the Snyder Act), the Secretary shall maintain a Community Health Aide Program in Alaska under which the Service—

"(1) provides for the training of Alaska Natives as health aides or community health practitioners;

"(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

"(3) provides for the establishment of teleconferencing capacity in health clinics located in or near such villages for use by community health aides or community health practitioners.

"(b) ACTIVITIES.—The Secretary, acting through the Community Health Aide Program under subsection (a), shall—

"(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to the villages served by the Program;

"(2) in order to provide such training, develop a curriculum that—

"(A) combines education in the theory of health care with supervised practical experience in the provision of health care;

"(B) provides instruction and practical experience in the provision of acute care, emer-

gency care, health promotion, disease prevention, and the efficient and effective management of clinic pharmacies, supplies, equipment, and facilities; and

"(C) promotes the achievement of the health status objective specified in section 3(b);

"(3) establish and maintain a Community Health Aide Certification Board to certify as community health aides or community health practitioners individuals who have successfully completed the training described in paragraph (1) or who can demonstrate equivalent experience;

"(4) develop and maintain a system which identifies the needs of community health aides and community health practitioners for continuing education in the provision of health care, including the areas described in paragraph (2)(B), and develop programs that meet the needs for such continuing education;

"(5) develop and maintain a system that provides close supervision of community health aides and community health practitioners; and

"(6) develop a system under which the work of community health aides and community health practitioners is reviewed and evaluated to assure the pro-

vision of quality health care, health promotion, and disease prevention services.

"SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.

"Subject to Section 102, the Secretary, acting through the Service, shall, through a funding agreement or otherwise, provide training for Indians in the administration and planning of tribal health programs.

"SEC. 123. HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROJECT.

"(a) PILOT PROGRAMS.—The Secretary may, through area offices, fund pilot programs for tribes and tribal organizations to address chronic shortages of health professionals.

"(b) PURPOSE.—It is the purpose of the health professions demonstration project under this section to—

"(1) provide direct clinical and practical experience in a service area to health professions students and residents from medical schools;

"(2) improve the quality of health care for Indians by assuring access to qualified health care professionals; and

"(3) provide academic and scholarly opportunities for health professionals serving Indian people by identifying and utilizing all academic and scholarly resources of the region.

"(c) ADVISORY BOARD.—A pilot program established under subsection (a) shall incorporate a program advisory board that shall be composed of representatives from the tribes and communities in the service area that will be served by the program.

"SEC. 124. SCHOLARSHIPS.

"Scholarships and loan reimbursements provided to individuals pursuant to this title shall be treated as 'qualified scholarships' for purposes of section 117 of the Internal Revenue Code of 1986.

"SEC. 125. NATIONAL HEALTH SERVICE CORPS.

"(a) LIMITATIONS.—The Secretary shall not—

"(1) remove a member of the National Health Services Corps from a health program operated by Indian Health Service or by a tribe or tribal organization under a funding agreement with the Service under the Indian Self-Determination and Education Assistance Act, or by urban Indian organizations; or

"(2) withdraw the funding used to support such a member;

unless the Secretary, acting through the Service, tribes or tribal organization, has ensured that the Indians receiving services from such member will experience no reduction in services.

"(b) DESIGNATION OF SERVICE AREAS AS HEALTH PROFESSIONAL SHORTAGE AREAS.—All service areas served by programs operated by the Service or by a tribe or tribal organization sunder the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization, shall be designated under section 332 of the Public Health Service Act (42 U.S.C. 254e) as Health Professional Shortage Areas.

"(c) FULL TIME EQUIVALENT.—National Health Service Corps scholars that qualify for the commissioned corps in the Public Health Service shall be exempt from the full time equivalent limitations of the National Health Service Corps and the Service when such scholars serve as commissioned corps officers in a health program operated by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization.

"SEC. 126. SUBSTANCE ABUSE COUNSELOR EDUCATION DEMONSTRATION PROJECT.

"(a) DEMONSTRATION PROJECTS.—The Secretary, acting through the Service, may enter into contracts with, or make grants to, accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible commu-

nity colleges to establish demonstration projects to develop educational curricula for substance abuse counseling.

"(b) USE OF FUNDS.—Funds provided under this section shall be used only for developing and providing educational curricula for substance abuse counseling (including paying salaries for instructors). Such curricula may be provided through satellite campus programs.

"(c) TERM OF GRANT.—A contract entered into or a grant provided under this section shall be for a period of 1 year. Such contract or grant may be renewed for an additional 1 year period upon the approval of the Secretary.

"(d) REVIEW OF APPLICATIONS.—Not later than 180 days after the date of the enactment of this Act, the Secretary, after consultation with Indian tribes and administrators of accredited tribally controlled community colleges, tribally controlled postsecondary vocational institutions, and eligible accredited and accessible community colleges, shall develop and issue criteria for the review and approval of applications for funding (including applications for renewals of funding) under this section. Such criteria shall ensure that demonstration projects established under this section promote the development of the capacity of such entities to educate substance abuse counselors.

"(e) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable grant recipients to comply with the provisions of this section.

"(f) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted under section 801 for fiscal year 1999, a report on the findings and conclusions derived from the demonstration projects conducted under this section.

"(g) DEFINITIONS.—In this section:

"(1) EDUCATIONAL CURRICULUM.—The term 'educational curriculum' means 1 or more of the following:

"(A) Classroom education.

"(B) Clinical work experience.

"(C) Continuing education workshops.

"(2) TRIBALLY CONTROLLED COMMUNITY COLLEGE.—The term 'tribally controlled community college' has the meaning given such term in section 2(a)(4) of the Tribally Controlled Community College Assistance Act of 1978 (25 U.S.C. 1801(a)(4)).

"(3) TRIBALLY CONTROLLED POSTSECONDARY VOCATIONAL INSTITUTION.—The term 'tribally controlled postsecondary vocational institution' has the meaning given such term in section 390(2) of the

Tribally Controlled Vocational Institutions Support Act of 1990 (20 U.S.C. 2397h(2)).

"SEC. 127. MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION.

"(a) STUDY AND LIST.—

"(1) IN GENERAL.—The Secretary and the Secretary of the Interior in consultation with Indian tribes and tribal organizations shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include or should include, training in the identification, prevention, education, referral or treatment of mental illness, dysfunctional or self-destructive behavior.

"(2) POSITIONS.—The positions referred to in paragraph (1) are—

"(A) staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

"(i) elementary and secondary education;

"(ii) social services, family and child welfare;

"(iii) law enforcement and judicial services; and

"(iv) alcohol and substance abuse;

"(B) staff positions within the Service; and

"(C) staff positions similar to those specified in subsection (b) and established and maintained by Indian tribes, tribal organizations, and urban Indian organizations, including positions established pursuant to funding agreements under the Indian Self-determination and Education Assistance Act, and this Act.

"(3) TRAINING CRITERIA.—

"(A) IN GENERAL.—The appropriate Secretary shall provide training criteria appropriate to each type of position specified in subsection (b)(1) and ensure that appropriate training has been or will be provided to any individual in any such position.

"(B) TRAINING.—With respect to any such individual in a position specified pursuant to subsection (b)(3), the respective Secretaries shall provide appropriate training or provide funds to an Indian tribe, tribal organization, or urban Indian organization for the training of appropriate individuals. In the case of a funding agreement, the appropriate Secretary shall

ensure that such training costs are included in the funding agreement, if necessary.

"(4) CULTURAL RELEVANCY.—Position specific training criteria shall be culturally relevant to Indians and Indian tribes and shall ensure that appropriate information regarding traditional health care practices is provided.

"(5) COMMUNITY EDUCATION.—

"(A) DEVELOPMENT.—The Service shall develop and implement, or on request of an Indian tribe or tribal organization, assist an Indian tribe or tribal organization, in developing and implementing a program of community education on mental illness.

"(B) TECHNICAL ASSISTANCE.—In carrying out this paragraph, the Service shall, upon the request of an Indian tribe or tribal organization, provide technical assistance to the Indian tribe or tribal organization to obtain and develop community educational materials on the identification, prevention, referral and treatment of mental illness, dysfunctional and self-destructive behavior.

"(b) STAFFING.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of the Act, the Director of the Service shall develop a plan under which the Service will increase the number of health care staff that are providing mental health services by at least 500 positions within 5 years after such date of enactment, with at least 200 of such positions devoted to child, adolescent, and family services. The allocation of such positions shall be subject to the provisions of section 102(a).

"(2) IMPLEMENTATION.—The plan developed under paragraph (1) shall be implemented under the Act of November 2, 1921 (25 U.S.C. 13) (commonly know as the 'Snyder Act').

"SEC. 128. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE II—HEALTH SERVICES

"SEC. 201. INDIAN HEALTH CARE IMPROVEMENT FUND.

"(a) IN GENERAL.—The Secretary may expend funds, directly or under the authority of the Indian Self-Determination and Education Assistance Act, that are appropriated under the authority of this section, for the purposes of—

"(1) eliminating the deficiencies in the health status and resources of all Indian tribes;

"(2) eliminating backlogs in the provision of health care services to Indians;

"(3) meeting the health needs of Indians in an efficient and equitable manner;

"(4) eliminating inequities in funding for both direct care and contract health service programs; and –

"(5) augmenting the ability of the Service to meet the following health service responsibilities with respect to those Indian tribes with the highest levels of health status and resource deficiencies:

"(A) clinical care, including inpatient care, outpatient care (including audiology, clinical eye and vision care), primary care, secondary and tertiary care, and long term care;

"(B) preventive health, including mammography and other cancer screening in accordance with section 207;

"(C) dental care;

"(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers,

and training of traditional health care practitioners;

"(E) emergency medical services;

"(F) treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians;

"(G) accident prevention programs;

"(H) home health care;

"(I) community health representatives;

"(J) maintenance and repair; and

"(K) traditional health care practices.

"(b) USE OF FUNDS.—

"(1) LIMITATION.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act, the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the 'Snyder Act'), or any other provision of law.

"(2) ALLOCATION.—

"(A) IN GENERAL.—Funds appropriated under the authority of this section shall be allocated to service units or Indian tribes or tribal organizations. The funds allocated to each tribe, tribal organization, or service unit under this

subparagraph shall be used to improve the health status and reduce the resource deficiency of each tribe served by such service unit, tribe or tribal organization.

"(B) APPORTIONMENT.—The apportionment of funds allocated to a service unit, tribe or tribal organization under subparagraph (A) among the health service responsibilities described in subsection (a)(4) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian tribes in accordance with this section and such rules as may be established under title VIII.

"(c) HEALTH STATUS AND RESOURCE DEFICIENCY.—In this section:

"(1) DEFINITION.—The term 'health status and resource deficiency' means the extent to which—

"(A) the health status objective set forth in section 3(2) is not being achieved; and

"(B) the Indian tribe or tribal organization does not have available to it the health resources it needs, taking into account the actual cost of providing health care services given local

geographic, climatic, rural, or other circumstances.

"(2) RESOURCES.—The health resources available to an Indian tribe or tribal organization shall include health resources provided by the Service as well as health resources used by the Indian Tribe or tribal organization, including services and financing systems provided by any Federal programs, private insurance, and programs of State or local governments.

"(3) REVIEW OF DETERMINATION.—The Secretary shall establish procedures which allow any Indian tribe or tribal organization to petition the Secretary for a review of any determination of the extent of the health status and resource deficiency of such tribe or tribal organization.

"(d) ELIGIBILITY.—Programs administered by any Indian tribe or tribal organization under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

"(e) REPORT.—Not later than the date that is 3 years after the date of enactment of this Act, the Secretary shall submit to the Congress the current health sta-

tus and resource deficiency report of the Service for each Indian tribe or service unit, including newly recognized or acknowledged tribes. Such report shall set out—

"(1) the methodology then in use by the Service for determining tribal health status and resource deficiencies, as well as the most recent application of that methodology;

"(2) the extent of the health status and resource deficiency of each Indian tribe served by the Service;

"(3) the amount of funds necessary to eliminate the health status and resource deficiencies of all Indian tribes served by the Service; and

"(4) an estimate of—

"(A) the amount of health service funds appropriated under the authority of this Act, or any other Act, including the amount of any funds transferred to the Service, for the preceding fiscal year which is allocated to each service unit, Indian tribe, or comparable entity;

"(B) the number of Indians eligible for health services in each service unit or Indian tribe or tribal organization; and

"(C) the number of Indians using the Service resources made available to each service

unit or Indian tribe or tribal organization, and, to the extent available, information on the waiting lists and number of Indians turned away for services due to lack of resources.

"(f) BUDGETARY RULE.—Funds appropriated under the authority of this section for any fiscal year shall be included in the base budget of the Service for the purpose of determining appropriations under this section in subsequent fiscal years.

"(g) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to diminish the primary responsibility of the Service to eliminate existing backlogs in unmet health care needs or to discourage the Service from undertaking additional efforts to achieve equity among Indian tribes and tribal organizations.

"(h) DESIGNATION.—Any funds appropriated under the authority of this section shall be designated as the 'Indian Health Care Improvement Fund'.

"SEC. 202. CATASTROPHIC HEALTH EMERGENCY FUND.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is hereby established an Indian Catastrophic Health Emergency Fund (referred to in this section as the 'CHEF') consisting of—

"(A) the amounts deposited under subsection (d); and

"(B) any amounts appropriated to the CHEF under this Act.

"(2) ADMINISTRATION.—The CHEF shall be administered by the Secretary solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

"(3) EQUITABLE ALLOCATION.—The CHEF shall be equitably allocated, apportioned or delegated on a service unit or area office basis, based upon a formula to be developed by the Secretary in consultation with the Indian tribes and tribal organizations through negotiated rulemaking under title VIII. Such formula shall take into account the added needs of service areas which are contract health service dependent.

"(4) NOT SUBJECT TO CONTRACT OR GRANT.—No part of the CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act.

"(5) ADMINISTRATION.—Amounts provided from the CHEF shall be administered by the area offices based upon priorities determined by the Indian tribes and tribal organizations within each service area, including a consideration of the needs of Indian tribes and tribal organizations which are contract health service-dependent.

"(b) REQUIREMENTS.—The Secretary shall, through the negotiated rulemaking process under title VIII, promulgate regulations consistent with the provisions of this section—

"(1) establish a definition of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the CHEF;

"(2) provide that a service unit, Indian tribe, or tribal organization shall not be eligible for reimbursement for the cost of treatment from the CHEF until its cost of treatment for any victim of such a catastrophic illness or disaster has reached a certain threshold cost which the Secretary shall establish at—

"(A) for 1999, not less than $19,000; and

"(B) for any subsequent year, not less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year;

"(3) establish a procedure for the reimbursement of the portion of the costs incurred by—

"(A) service units, Indian tribes, or tribal organizations, or facilities of the Service; or

"(B) non-Service facilities or providers whenever otherwise authorized by the Service;

in rendering treatment that exceeds threshold cost described in paragraph (2);

"(4) establish a procedure for payment from the CHEF in cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

"(5) establish a procedure that will ensure that no payment shall be made from the CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private

source of reimbursement for which the patient is eligible.

"(c) LIMITATION.—Amounts appropriated to the CHEF under this section shall not be used to offset or limit appropriations made to the Service under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act) or any other law.

"(d) DEPOSITS.—There shall be deposited into the CHEF all reimbursements to which the Service is entitled from any Federal, State, local, or private source (including third party insurance) by reason of treatment rendered to any victim of a disaster or catastrophic illness the cost of which was paid from the CHEF.

"SEC. 203. HEALTH PROMOTION AND DISEASE PREVENTION SERVICES.

"(a) FINDINGS.—Congress finds that health promotion and disease prevention activities will—

"(1) improve the health and well-being of Indians; and

"(2) reduce the expenses for health care of Indians.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service and through Indian tribes and tribal organizations, shall provide health promotion and

disease prevention services to Indians so as to achieve the health status objective set forth in section 3(b).

"(c) DISEASE PREVENTION AND HEALTH PROMOTION.—In this section:

"(1) DISEASE PREVENTION.—The term 'disease prevention' means the reduction, limitation, and prevention of disease and its complications, and the reduction in the consequences of such diseases, including—

"(A) controlling—

"(i) diabetes;

"(ii) high blood pressure;

"(iii) infectious agents;

"(iv) injuries;

"(v) occupational hazards and disabilities;

"(vi) sexually transmittable diseases; and

"(vii) toxic agents; and

"(B) providing—

"(i) for the fluoridation of water; and

"(ii) immunizations.

"(2) HEALTH PROMOTION.—The term 'health promotion' means fostering social, economic, envi-

ronmental, and personal factors conducive to health, including—

"(A) raising people's awareness about health matters and enabling them to cope with health problems by increasing their knowledge and providing them with valid information;

"(B) encouraging adequate and appropriate diet, exercise, and sleep;

"(C) promoting education and work in conformity with physical and mental capacity;

"(E) making available suitable housing, safe water, and sanitary facilities;

"(F) improving the physical economic, cultural, psychological, and social environment;

"(G) promoting adequate opportunity for spiritual, religious, and traditional practices; and

"(H) adequate and appropriate programs including—

"(i) abuse prevention (mental and physical);

"(iii) community health;

"(iv) community safety;

"(v) consumer health education;

"(vi) diet and nutrition;

"(vii) disease prevention (communicable, immunizations, HIV/AIDS);

"(viii) environmental health;

"(ix) exercise and physical fitness;

"(x) fetal alcohol disorders;

"(xi) first aid and CPR education;

"(xii) human growth and development;

"(xiii) injury prevention and personal safety;

"(xiv) mental health (emotional, self-worth);

"(xv) personal health and wellness practices;

"(xvi) personal capacity building;

"(xvii) prenatal, pregnancy, and infant care;

"(xviii) psychological well being;

"(xix) reproductive health (family planning);

"(xx) safe and adequate water;

"(xxi) safe housing;

"(xxii) safe work environments;

"(xxiii) stress control;

"(xxiv) substance abuse;

"(xxv) sanitary facilities;

"(xxvi) tobacco use cessation and reduction;

"(xxvii) violence prevention; and

"(xxviii) such other activities identified by the Service, an Indian tribe or tribal organization, to promote the achievement of the objective described in section 3(b).

"(d) EVALUATION.—The Secretary, after obtaining input from affected Indian tribes and tribal organizations, shall submit to the President for inclusion in each statement which is required to be submitted to Congress under section 801 an evaluation of—

"(1) the health promotion and disease prevention needs of Indians;

"(2) the health promotion and disease prevention activities which would best meet such needs;

"(3) the internal capacity of the Service to meet such needs; and

"(4) the resources which would be required to enable the Service to undertake the health promotion and disease prevention activities necessary to meet such needs.

"SEC. 204. DIABETES PREVENTION, TREATMENT, AND CONTROL.

"(a) DETERMINATION.—The Secretary, in consultation with Indian tribes and tribal organizations, shall determine—

"(1) by tribe, tribal organization, and service unit of the Service, the prevalence of, and the types of complications resulting from, diabetes among Indians; and

"(2) based on paragraph (1), the measures (including patient education) each service unit should take to reduce the prevalence of, and prevent, treat, and control the complications resulting from, diabetes among Indian tribes within that service unit.

"(b) SCREENING.—The Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic. Such screening may be done by an Indian tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination and Education Assistance Act.

"(c) CONTINUED FUNDING.—The Secretary shall continue to fund, through fiscal year 2012, each effective model diabetes project in existence on the date of the enactment of this Act and such other diabetes programs op-

erated by the Secretary or by Indian tribes and tribal organizations and any additional programs added to meet existing diabetes needs. Indian tribes and tribal organizations shall receive recurring funding for the diabetes programs which they operate pursuant to this section. Model diabetes projects shall consult, on a regular basis, with tribes and tribal organizations in their regions regarding diabetes needs and provide technical expertise as needed.

"(d) DIALYSIS PROGRAMS.—The Secretary shall provide funding through the Service, Indian tribes and tribal organizations to establish dialysis programs, including funds to purchase dialysis equipment and provide necessary staffing.

"(e) OTHER ACTIVITIES.—The Secretary shall, to the extent funding is available—

"(1) in each area office of the Service, consult with Indian tribes and tribal organizations regarding programs for the prevention, treatment, and control of diabetes;

"(2) establish in each area office of the Service a registry of patients with diabetes to track the prevalence of diabetes and the complications from diabetes in that area; and

"(3) ensure that data collected in each area office regarding diabetes and related complications

among Indians is disseminated to tribes, tribal organizations, and all other area offices.

"SEC. 205. SHARED SERVICES.

"(a) IN GENERAL.—The Secretary, acting through the Service and notwithstanding any other provision of law, is authorized to enter into funding agreements or other arrangements with Indian tribes or tribal organizations for the delivery of long-term care and similar services to Indians. Such projects shall provide for the sharing of staff or other services between a Service or tribal facility and a long-term care or other similar facility owned and operated (directly or through a funding agreement) by such Indian tribe or tribal organization.

"(b) REQUIREMENTS.—A funding agreement or other arrangement entered into pursuant to subsection (a)—

"(1) may, at the request of the Indian tribe or tribal organization, delegate to such tribe or tribal organization such powers of supervision and control over Service employees as the Secretary deems necessary to carry out the purposes of this section;

"(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the tribal facility be allocated propor-

tionately between the Service and the tribe or tribal organization; and

"(3) may authorize such tribe or tribal organization to construct, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

"(c) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

"(d) USE OF EXISTING FACILITIES.—The Secretary shall encourage the use for long-term or similar care of existing facilities that are under-utilized or allow the use of swing beds for such purposes.

"SEC. 206. HEALTH SERVICES RESEARCH.

"(a) FUNDING.—The Secretary shall make funding available for research to further the performance of the health service responsibilities of the Service, Indian tribes, and tribal organizations and shall coordinate the activities of other Agencies within the Department to address these research needs.

"(b) ALLOCATION.—Funding under subsection (a) shall be allocated equitably among the area offices. Each area office shall award such funds competitively within that area.

"(c) ELIGIBILITY FOR FUNDS.—Indian tribes and tribal organizations receiving funding from the Service under the authority of the Indian Self-Determination and Education Assistance Act shall be given an equal opportunity to compete for, and receive, research funds under this section.

"(d) USE.—Funds received under this section may be used for both clinical and non-clinical research by Indian tribes and tribal organizations and shall be distributed to the area offices. Such area offices may make grants using such funds within each area.

"SEC. 207. MAMMOGRAPHY AND OTHER CANCER SCREENING.

"The Secretary, through the Service or through Indian tribes or tribal organizations, shall provide for the following screening:

"(1) Mammography (as defined in section 1861(jj) of the Social Security Act) for Indian women at a frequency appropriate to such women under national standards, and under such terms and conditions as are consistent with standards established by the Secretary to assure the safety and accuracy of screening mammography under part B of title XVIII of the Social Security Act.

"(2) Other cancer screening meeting national standards.

"SEC. 208. PATIENT TRAVEL COSTS.

"The Secretary, acting through the Service, Indian tribes and tribal organizations shall provide funds for the following patient travel costs, including appropriate and necessary qualified escorts, associated with receiving health care services provided (either through direct or contract care or through funding agreements entered into pursuant to the Indian Self-Determination and Education Assistance Act) under this Act:

"(1) Emergency air transportation and non-emergency air transportation where ground transportation is infeasible.

"(2) Transportation by private vehicle, specially equipped vehicle and ambulance.

"(3) Transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

"SEC. 209. EPIDEMIOLOGY CENTERS.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—In addition to those centers operating 1 day prior to the date of enactment of this Act, (including those centers for which funding is currently being provided through funding agree-

ments under the Indian Self-Determination and Education Assistance Act), the Secretary shall, not later than 180 days after such date of enactment, establish and fund an epidemiology center in each service area which does not have such a center to carry out the functions described in paragraph (2). Any centers established under the preceding sentence may be operated by Indian tribes or tribal organizations pursuant to funding agreements under the Indian Self-Determination and Education Assistance Act, but funding under such agreements may not be divisible.

"(2) FUNCTIONS.—In consultation with and upon the request of Indian tribes, tribal organizations and urban Indian organizations, each area epidemiology center established under this subsection shall, with respect to such area shall—

"(A) collect data related to the health status objective described in section 3(b), and monitor the progress that the Service, Indian tribes, tribal organizations, and urban Indian organizations have made in meeting such health status objective;

"(B) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

"(C) assist Indian tribes, tribal organizations, and urban Indian organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

"(D) make recommendations for the targeting of services needed by tribal, urban, and other Indian communities;

"(E) make recommendations to improve health care delivery systems for Indjans and urban Indians;

"(F) provide requested technical assistance to Indian Tribes and urban Indian organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

"(G) provide disease surveillance and assist Indian tribes, tribal organizations, and urban Indian organizations to promote public health.

"(3) TECHNICAL ASSISTANCE.—The director of the Centers for Disease Control and Prevention shall

provide technical assistance to the centers in carrying out the requirements of this subsection.

"(b) FUNDING.—The Secretary may make funding available to Indian tribes, tribal organizations, and eligible intertribal consortia or urban Indian organizations to conduct epidemiological studies of Indian communities.

"SEC. 210. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide funding to Indian tribes, tribal organizations, and urban Indian organizations to develop comprehensive school health education programs for children from preschool through grade 12 in schools for the benefit of Indian and urban Indian children.

"(b) USE OF FUNDS.—Funds awarded under this section may be used to—

"(1) develop and implement health education curricula both for regular school programs and after school programs;

"(2) train teachers in comprehensive school health education curricula;

"(3) integrate school-based, community-based, and other public and private health promotion efforts;

"(4) encourage healthy, tobacco-free school environments;

"(5) coordinate school-based health programs with existing services and programs available in the community;

"(6) develop school programs on nutrition education, personal health, oral health, and fitness;

"(7) develop mental health wellness programs;

"(8) develop chronic disease prevention programs;

"(9) develop substance abuse prevention programs;

"(10) develop injury prevention and safety education programs;

"(11) develop activities for the prevention and control of communicable diseases;

"(12) develop community and environmental health education programs that include traditional health care practitioners;

"(13) carry out violence prevention activities; and

"(14) carry out activities relating to such other health issues as are appropriate.

"(c) TECHNICAL ASSISTANCE.—The Secretary shall, upon request, provide technical assistance to Indian tribes,

tribal organization and urban Indian organizations in the development of comprehensive health education plans, and the dissemination of comprehensive health education materials and information on existing health programs and resources.

"(d) CRITERIA.—The Secretary, in consultation with Indian tribes tribal organizations, and urban Indian organizations shall establish criteria for the review and approval of applications for funding under this section.

"(e) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—

"(1) DEVELOPMENT.—The Secretary of the Interior, acting through the Bureau of Indian Affairs and in cooperation with the Secretary and affected Indian tribes and tribal organizations, shall develop a comprehensive school health education program for children from preschool through grade 12 for use in schools operated by the Bureau of Indian Affairs.

"(2) REQUIREMENTS.—The program developed under paragraph (1) shall include—

"(A) school programs on nutrition education, personal health, oral health, and fitness;

"(B) mental health wellness programs;

"(C) chronic disease prevention programs;

"(D) substance abuse prevention programs;

"(E) injury prevention and safety education programs; and

"(F) activities for the prevention and control of communicable diseases.

"(3) TRAINING AND COORDINATION.—The Secretary of the Interior shall—

"(A) provide training to teachers in comprehensive school health education curricula;

"(B) ensure the integration and coordination of school-based programs with existing services and health programs available in the community; and

"(C) encourage healthy, tobacco-free school environments.

"SEC. 211. INDIAN YOUTH PROGRAM.

"(a) IN GENERAL.—The Secretary, acting through the Service, is authorized to provide funding to Indian tribes, tribal organizations, and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian and urban Indian preadolescent and adolescent youths.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—Funds made available under this section may be used to—

"(A) develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate cultural values, community and family involvement, and traditional health care practitioners; and

"(B) develop and provide community training and education.

"(2) LIMITATION.—Funds made available under this section may not be used to provide services described in section 707(c).

"(c) REQUIREMENTS.—The Secretary shall—

"(1) disseminate to Indian tribes, tribal organizations, and urban Indian organizations information regarding models for the delivery of comprehensive health care services to Indian and urban Indian adolescents;

"(2) encourage the implementation of such models; and

"(3) at the request of an Indian tribe, tribal organization, or urban Indian organization, provide technical assistance in the implementation of such models.

"(d) CRITERIA.—The Secretary, in consultation with Indian tribes, tribal organization, and urban Indian organizations, shall establish criteria for the review and approval of applications under this section.

"SEC. 212. PREVENTION, CONTROL, AND ELIMINATION OF COMMUNICABLE AND INFECTIOUS DISEASES.

"(a) IN GENERAL.—The Secretary, acting through the Service after consultation with Indian tribes, tribal organizations, urban Indian organizations, and the Centers for Disease Control and Prevention, may make funding available to Indian tribes and tribal organizations for—

"(1) projects for the prevention, control, and elimination of communicable and infectious diseases, including tuberculosis, hepatitis, HIV, respiratory syncitial virus, hanta virus, sexually transmitted diseases, and H. Pylori;

"(2) public information and education programs for the prevention, control, and elimination of communicable and infectious diseases; and

"(3) education, training, and clinical skills improvement activities in the prevention, control, and elimination of communicable and infectious diseases for health professionals, including allied health professionals.

"(b) REQUIREMENT OF APPLICATION.—The Secretary may provide funds under subsection (a) only if an application or proposal for such funds is submitted.

"(c) TECHNICAL ASSISTANCE AND REPORT.—In carrying out this section, the Secretary—

"(1) may, at the request of an Indian tribe or tribal organization, provide technical assistance; and

"(2) shall prepare and submit, biennially, a report to Congress on the use of funds under this section and on the progress made toward the prevention, control, and elimination of communicable and infectious diseases among Indians and urban Indians.

"SEC. 213. AUTHORITY FOR PROVISION OF OTHER SERVICES.

"(a) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, and tribal organizations, may provide funding under this Act to meet the objective set forth in section 3 through health care related services and programs not otherwise described in this Act. Such services and programs shall include services and programs related to—

"(1) hospice care and assisted living;

"(2) long-term health care;

"(3) home- and community-based services;

"(4) public health functions; and

"(5) traditional health care practices.

"(b) AVAILABILITY OF SERVICES FOR CERTAIN INDIVIDUALS.—At the discretion of the Service, Indian tribe, or tribal organization, services hospice care, home health care (under section 201), home- and community-based care, assisted living, and long term care may be provided (on a cost basis) to individuals otherwise ineligible for the health care benefits of the Service. Any funds received under this subsection shall not be used to offset or limit the funding allocated to a tribe or tribal organization.

"(c) DEFINITIONS.—In this section:

"(1) HOME- AND COMMUNITY-BASED SERVICES.—The term 'home- and community-based services' means 1 or more of the following:

"(A) Homemaker/home health aide services.

"(B) Chore services.

"(C) Personal care services.

"(D) Nursing care services provided outside of a nursing facility by, or under the supervision of, a registered nurse.

"(E) Training for family members.

"(F) Adult day care.

"(G) Such other home- and community-based services as the Secretary or a tribe or tribal organization may approve.

"(2) HOSPICE CARE.—The term 'hospice care' means the items and services specified in subparagraphs (A) through (H) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)), and such other services which an Indian tribe or tribal organization determines are necessary and appropriate to provide in furtherance of such care.

"(3) PUBLIC HEALTH FUNCTIONS.—The term 'public health functions' means public health related programs, functions, and services including assessments, assurances, and policy development that Indian tribes and tribal organizations are authorized and encouraged, in those circumstances where it meets their needs, to carry out by forming collaborative relationships with all levels of local, State, and Federal governments.

"SEC. 214. INDIAN WOMEN'S HEALTH CARE.

"The Secretary acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall provide funding to monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs adminis-

tered by the Service, in order to improve and enhance the treatment models of care for Indian women.

"SEC. 215. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

"(a) STUDY AND MONITORING PROGRAMS.—The Secretary and the Service shall, in conjunction with other appropriate Federal agencies and in consultation with concerned Indian tribes and tribal organizations, conduct a study and carry out ongoing monitoring programs to determine the trends that exist in the health hazards posed to Indian miners and to Indians on or near Indian reservations and in Indian communities as a result of environmental hazards that may result in chronic or life-threatening health problems. Such hazards include nuclear resource development, petroleum contamination, and contamination of the water source or of the food chain. Such study (and any reports with respect to such study) shall include—

"(1) an evaluation of the nature and extent of health problems caused by environmental hazards currently exhibited among Indians and the causes of such health problems;

"(2) an analysis of the potential effect of ongoing and future environmental resource development on or near Indian reservations and communities in-

cluding the cumulative effect of such development over time on health;

"(3) an evaluation of the types and nature of activities, practices, and conditions causing or affecting such health problems including uranium mining and milling, uranium mine tailing deposits, nuclear power plant operation and construction, and nuclear waste disposal, oil and gas production or transportation on or near Indian reservations or communities, and other development that could affect the health of Indians and their water supply and food chain;

"(4) a summary of any findings or recommendations provided in Federal and State studies, reports, investigations, and inspections during the 5 years prior to the date of the enactment of this Act that directly or indirectly relate to the activities, practices, and conditions affecting the health or safety of such Indians; and

"(5) a description of the efforts that have been made by Federal and State agencies and resource and economic development companies to effectively carry out an education program for such Indians regarding the health and safety hazards of such development.

"(b) DEVELOPMENT OF HEALTH CARE PLANS.—Upon the completion of the study under subsection (a), the Secretary and the Service shall take into account the results of such study and, in consultation with Indian tribes and tribal organizations, develop a health care plan to address the health problems that were the subject of such study. The plans shall include—

"(1) methods for diagnosing and treating Indians currently exhibiting such health problems;

"(2) preventive care and testing for Indians who may be exposed to such health hazards, including the monitoring of the health of individuals who have or may have been exposed to excessive amounts of radiation, or affected by other activities that have had or could have a serious impact upon the health of such individuals; and

"(3) a program of education for Indians who, by reason of their work or geographic proximity to such nuclear or other development activities, may experience health problems.

"(c) SUBMISSION TO CONGRESS.—

"(1) GENERAL REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary and the Service shall submit to Congress

a report concerning the study conducted under subsection (a).

"(2) HEALTH CARE PLAN REPORT.—Not later than 1 year after the date on which the report under paragraph (1) is submitted to Congress, the Secretary and the Service shall submit to Congress the health care plan prepared under subsection (b). Such plan shall include recommended activities for the implementation of the plan, as well as an evaluation of any activities previously undertaken by the Service to address the health problems involved.

"(d) TASK FORCE.—

"(1) ESTABLISHED.—There is hereby established an Intergovernmental Task Force (referred to in this section as the 'task force') that shall be composed of the following individuals (or their designees):

"(A) The Secretary of Energy.

"(B) The Administrator of the Environmental Protection Agency.

"(C) The Director of the Bureau of Mines.

"(D) The Assistant Secretary for Occupational Safety and Health.

"(E) The Secretary of the Interior.

"(2) DUTIES.—The Task Force shall identify existing and potential operations related to nuclear resource development or other environmental hazards that affect or may affect the health of Indians on or near an Indian reservation or in an Indian community, and enter into activities to correct existing health hazards and ensure that current and future health problems resulting from nuclear resource or other development activities are minimized or reduced.

"(3) ADMINISTRATIVE PROVISIONS.—The Secretary shall serve as the chairperson of the Task Force. The Task Force shall meet at least twice each year. Each member of the Task Force shall furnish necessary assistance to the Task Force.

"(e) PROVISION OF APPROPRIATE MEDICAL CARE.—In the case of any Indian who—

"(1) as a result of employment in or near a uranium mine or mill or near any other environmental hazard, suffers from a work related illness or condition;

"(2) is eligible to receive diagnosis and treatment services from a Service facility; and

"(3) by reason of such Indian's employment, is entitled to medical care at the expense of such mine

or mill operator or entity responsible for the environmental hazard;

the Service shall, at the request of such Indian, render appropriate medical care to such Indian for such illness or condition and may recover the costs of any medical care so rendered to which such Indian is entitled at the expense of such operator or entity from such operator or entity. Nothing in this subsection shall affect the rights of such Indian to recover damages other than such costs paid to the Service from the employer for such illness or condition.

"SEC. 216. ARIZONA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"(a) IN GENERAL.—For fiscal years beginning with the fiscal year ending September 30, 1983, and ending with the fiscal year ending September 30, 2012, the State of Arizona shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health care services to members of federally recognized Indian Tribes of Arizona.

"(b) LIMITATION.—The Service shall not curtail any health care services provided to Indians residing on Federal reservations in the State of Arizona if such curtailment is due to the provision of contract services in such State pursuant to the designation of such State as a con-

tract health service delivery area pursuant to subsection (a).

"SEC. 217. CALIFORNIA CONTRACT HEALTH SERVICES DEMONSTRATION PROGRAM.

"(a) IN GENERAL.—The Secretary may fund a program that utilizes the California Rural Indian Health Board as a contract care intermediary to improve the accessibility of health services to California Indians.

"(b) REIMBURSEMENT OF BOARD.—

"(1) AGREEMENT.—The Secretary shall enter into an agreement with the California Rural Indian Health Board to reimburse the Board for costs (including reasonable administrative costs) incurred pursuant to this section in providing medical treatment under contract to California Indians described in section 809(b) throughout the California contract health services delivery area described in section 218 with respect to high-cost contract care cases.

"(2) ADMINISTRATION.—Not more than 5 percent of the amounts provided to the Board under this section for any fiscal year may be used for reimbursement for administrative expenses incurred by the Board during such fiscal year.

"(3) LIMITATION.—No payment may be made for treatment provided under this section to the ex-

tent that payment may be made for such treatment under the Catastrophic Health Emergency Fund described in section 202 or from amounts appropriated or otherwise made available to the California contract health service delivery area for a fiscal year.

"(c) ADVISORY BOARD.—There is hereby established an advisory board that shall advise the California Rural Indian Health Board in carrying out this section. The advisory board shall be composed of representatives, selected by the California Rural Indian Health Board, from not less than 8 tribal health programs serving California Indians covered under this section, at least 50 percent of whom are not affiliated with the California Rural Indian Health Board.

"SEC. 218. CALIFORNIA AS A CONTRACT HEALTH SERVICE DELIVERY AREA.

"The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura shall be designated as a contract health service delivery area by the Service for the purpose of providing contract health services to Indians in such State, except that any of the counties described in this section may be included

in the contract health services delivery area if funding is specifically provided by the Service for such services in those counties.

"SEC. 219. CONTRACT HEALTH SERVICES FOR THE TRENTON SERVICE AREA.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide contract health services to members of the Turtle Mountain Band of Chippewa Indians that reside in the Trenton Service Area of Divide, McKenzie, and Williams counties in the State of North Dakota and the adjoining counties of Richland, Roosevelt, and Sheridan in the State of Montana.

"(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as expanding the eligibility of members of the Turtle Mountain Band of Chippewa Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

"The Service shall provide funds for health care programs and facilities operated by Indian tribes and tribal organizations under funding agreements with the Service entered into under the Indian Self-Determination and Education Assistance Act on the same basis as such funds

are provided to programs and facilities operated directly by the Service.

"SEC. 221. LICENSING.

"Health care professionals employed by Indian Tribes and tribal organizations to carry out agreements under the Indian Self-Determination and Education Assistance Act, shall, if licensed in any State, be exempt from the licensing requirements of the State in which the agreement is performed.

"SEC. 222. AUTHORIZATION FOR EMERGENCY CONTRACT HEALTH SERVICES.

"With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider or in a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

"SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

"(a) REQUIREMENT.—The Service shall respond to a notification of a claim by a provider of a contract care service with either an individual purchase order or a denial of the claim within 5 working days after the receipt of such notification.

"(b) FAILURE TO RESPOND.—If the Service fails to respond to a notification of a claim in accordance with

subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

"(c) PAYMENT.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

"SEC. 224. LIABILITY FOR PAYMENT.

"(a) NO LIABILITY.—A patient who receives contract health care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

"(b) NOTIFICATION.—The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services.

"(c) LIMITATION.—Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 223(b), the provider shall have no further recourse against the patient who received the services involved.

"SEC. 225. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE III—FACILITIES

"SEC. 301. CONSULTATION, CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

"(a) CONSULTATION.—Prior to the expenditure of, or the making of any firm commitment to expend, any funds appropriated for the planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall—

"(1) consult with any Indian tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

"(2) ensure, whenever practicable, that such facility meets the construction standards of any nationally recognized accrediting body by not later than 1 year after the date on which the construction or renovation of such facility is completed.

"(b) CLOSURE OF FACILITIES.—

"(1) IN GENERAL.—Notwithstanding any provision of law other than this subsection, no Service hospital or outpatient health care facility or any inpatient service or special care facility operated by

the Service, may be closed if the Secretary has not submitted to the Congress at least 1 year prior to the date such proposed closure an evaluation of the impact of such proposed closure which specifies, in addition to other considerations—

"(A) the accessibility of alternative health care resources for the population served by such hospital or facility;

"(B) the cost effectiveness of such closure;

"(C) the quality of health care to be provided to the population served by such hospital or facility after such closure;

"(D) the availability of contract health care funds to maintain existing levels of service;

"(E) the views of the Indian tribes served by such hospital or facility concerning such closure;

"(F) the level of utilization of such hospital or facility by all eligible Indians; and

"(G) the distance between such hospital or facility and the nearest operating Service hospital.

"(2) TEMPORARY CLOSURE.—Paragraph (1) shall not apply to any temporary closure of a facility

or of any portion of a facility if such closure is necessary for medical, environmental, or safety reasons.

"(c) PRIORITY SYSTEM.—

"(1) ESTABLISHMENT.—The Secretary shall establish a health care facility priority system, that shall—

"(A) be developed with Indian tribes and tribal organizations through negotiated rulemaking under section 802;

"(B) give the needs of Indian tribes' the highest priority; and

"(C) at a minimum, include the lists required in paragraph (2)(B) and the methodology required in paragraph (2)(E);

except that the priority of any project established under the construction priority system in effect on the date of this Act shall not be affected by any change in the construction priority system taking place thereafter if the project was identified as one of the top 10 priority inpatient projects or one of the top 10 outpatient projects in the Indian Health Service budget justification for fiscal year 2000, or if the project had completed both Phase I and Phase II of the construction priority system in effect on the date of this Act.

"(2) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report that includes—

"(A) a description of the health care facility priority system of the Service, as established under paragraph (1);

"(B) health care facility lists, including—

"(i) the total health care facility planning, design, construction and renovation needs for Indians;

"(ii) the 10 top-priority inpatient care facilities;

"(iii) the 10 top-priority outpatient care facilities;

"(iv) the 10 top-priority specialized care facilities (such as long-term care and alcohol and drug abuse treatment); and

"(v) any staff quarters associated with such prioritized facilities;

"(C) the justification for the order of priority among facilities;

"(D) the projected cost of the projects involved; and

"(E) the methodology adopted by the Service in establishing priorities under its health care facility priority system.

"(3) CONSULTATION.—In preparing each report required under paragraph (2) (other than the initial report) the Secretary shall annually—

"(A) consult with, and obtain information on all health care facilities needs from, Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act; and

"(B) review the total unmet needs of all tribes and tribal organizations for health care facilities (including staff quarters), including needs for renovation and expansion of existing facilities.

"(4) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluat-

ing the needs of facilities operated directly by the Service.

"(5) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of Service and non-Service facilities, operated under funding agreements in accordance with the Indian Self-Determination and Education Assistance Act are fully and equitably integrated into the health care facility priority system.

"(d) REVIEW OF NEED FOR FACILITIES.—

"(1) REPORT.—Beginning in 2001, the Secretary shall annually submit to the President, for inclusion in the report required to be transmitted to Congress under section 801 of this Act, a report which sets forth the needs of the Service and all Indian tribes and tribal organizations, including urban Indian organizations, for inpatient, outpatient and specialized care facilities, including the needs for renovation and expansion of existing facilities .

"(2) CONSULTATION.—In preparing each report required under paragraph (1) (other than the initial report), the Secretary shall consult with Indian tribes and tribal organizations including those tribes or tribal organizations operating health programs or facilities under any funding agreement entered into

with the Service under the Indian Self-Determination and Education Assistance Act, and with urban Indian organizations.

"(3) CRITERIA.—For purposes of this subsection, the Secretary shall, in evaluating the needs of facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating the needs of facilities operated directly by the Service.

"(4) EQUITABLE INTEGRATION.—The Secretary shall ensure that the planning, design, construction, and renovation needs of facilities operated under funding agreements, in accordance with the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the development of the health facility priority system.–

"(5) ANNUAL NOMINATIONS.—Each year the Secretary shall provide an opportunity for the nomination of planning, design, and construction projects by the Service and all Indian tribes and tribal organizations for consideration under the health care facility priority system.

"(e) INCLUSION OF CERTAIN PROGRAMS.—All funds appropriated under the Act of November 2, 1921 (25 U.S.C. 13), for the planning, design, construction, or renovation of health facilities for the benefit of an Indian tribe or tribes shall be subject to the provisions of section 102 of the Indian Self-Determination and Education Assistance Act.

"(f) INNOVATIVE APPROACHES.—The Secretary shall consult and cooperate with Indian tribes, tribal organizations and urban Indian organizations in developing innovative approaches to address all or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

"SEC. 302. SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES.

"(a) FINDINGS.—Congress finds and declares that—

"(1) the provision of safe water supply facilities and sanitary sewage and solid waste disposal facilities is primarily a health consideration and function;

"(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of such facilities;

"(3) the long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing such facilities and other preventive health measures;

"(4) many Indian homes and communities still lack safe water supply facilities and sanitary sewage and solid waste disposal facilities; and

"(5) it is in the interest of the United States, and it is the policy of the United States, that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply facilities and sanitary sewage waste disposal facilities as soon as possible.

"(b) PROVISION OF FACILITIES AND SERVICES.—

"(1) IN GENERAL.—In furtherance of the findings and declarations made in subsection (a), Congress reaffirms the primary responsibility and authority of the Service to provide the necessary sanitation facilities and services as provided in section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a).

"(2) ASSISTANCE.—The Secretary, acting through the Service, is authorized to provide under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a)—

"(A) financial and technical assistance to Indian tribes, tribal organizations and Indian communities in the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the tribe or tribal organization;

"(B) ongoing technical assistance and training in the management of utility organizations which operate and maintain sanitation facilities; and

"(C) priority funding for the operation, and maintenance assistance for, and emergency repairs to, tribal sanitation facilities when necessary to avoid an imminent health threat or to protect the investment in sanitation facilities and the investment in the health benefits gained through the provision of sanitation facilities.

"(3) PROVISIONS RELATING TO FUNDING.—Notwithstanding any other provision of law—

"(A) the Secretary of Housing and Urban Development is authorized to transfer funds ap-

propriated under the Native American Housing Assistance and Self-Determination Act of 1996 to the Secretary of Health and Human Services;

"(B) the Secretary of Health and Human Services is authorized to accept and use such funds for the purpose of providing sanitation facilities and services for Indians under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a);

"(C) unless specifically authorized when funds are appropriated, the Secretary of Health and Human Services shall not use funds appropriated under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a) to provide sanitation facilities to new homes constructed using funds provided by the Department of Housing and Urban Development;

"(D) the Secretary of Health and Human Services is authorized to accept all Federal funds that are available for the purpose of providing sanitation facilities and related services and place those funds into funding agreements, authorized under the Indian Self-Determination and Education Assistance Act, between the Sec-

retary and Indian tribes and tribal organizations;

"(E) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to fund up to 100 percent of the amount of a tribe's loan obtained under any Federal program for new projects to construct eligible sanitation facilities to serve Indian homes;

"(F) the Secretary may permit funds appropriated under the authority of section 4 of the Act of August 5, 1954 (42 U.S.C. 2004) to be used to meet matching or cost participation requirements under other Federal and non-Federal programs for new projects to construct eligible sanitation facilities;

"(G) all Federal agencies are authorized to transfer to the Secretary funds identified, granted, loaned or appropriated and thereafter the Department's applicable policies, rules, regulations shall apply in the implementation of such projects;

"(H) the Secretary of Health and Human Services shall enter into inter-agency agree-

ments with the Bureau of Indian Affairs, the Department of Housing and Urban Development, the Department of Agriculture, the Environmental Protection Agency and other appropriate Federal agencies, for the purpose of providing financial assistance for safe water supply and sanitary sewage disposal facilities under this Act; and

"(I) the Secretary of Health and Human Services shall, by regulation developed through rulemaking under section 802, establish standards applicable to the planning, design and construction of water supply and sanitary sewage and solid waste disposal facilities funded under this Act.

"(c) 10-YEAR FUNDING PLAN.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, shall develop and implement a 10-year funding plan to provide safe water supply and sanitary sewage and solid waste disposal facilities serving existing Indian homes and communities, and to new and renovated Indian homes.

"(d) CAPABILITY OF TRIBE OR COMMUNITY.—The financial and technical capability of an Indian tribe or community to safely operate and maintain a sanitation fa-

cility shall not be a prerequisite to the provision or construction of sanitation facilities by the Secretary.

"(e) FINANCIAL ASSISTANCE.—The Secretary may provide financial assistance to Indian tribes, tribal organizations and communities for the operation, management, and maintenance of their sanitation facilities.

"(f) RESPONSIBILITY FOR FEES FOR OPERATION AND MAINTENANCE.—The Indian family, community or tribe involved shall have the primary responsibility to establish, collect, and use reasonable user fees, or otherwise set aside funding, for the purpose of operating and maintaining sanitation facilities. If a community facility is threatened with imminent failure and there is a lack of tribal capacity to maintain the integrity or the health benefit of the facility, the Secretary may assist the Tribe in the resolution of the problem on a short term basis through cooperation with the emergency coordinator or by providing operation and maintenance service.

"(g) ELIGIBILITY OF CERTAIN TRIBES OR ORGANIZATIONS.—Programs administered by Indian tribes or tribal organizations under the authority of the Indian Self-Determination and Education Assistance Act shall be eligible for—

"(1) any funds appropriated pursuant to this section; and

"(2) any funds appropriated for the purpose of providing water supply, sewage disposal, or solid waste facilities;

on an equal basis with programs that are administered directly by the Service.

"(h) REPORT.—

"(1) IN GENERAL.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, a report which sets forth—

"(A) the current Indian sanitation facility priority system of the Service;

"(B) the methodology for determining sanitation deficiencies;

"(C) the level of initial and final sanitation deficiency for each type sanitation facility for each project of each Indian tribe or community; and

"(D) the amount of funds necessary to reduce the identified sanitation deficiency levels of all Indian tribes and communities to a level I sanitation deficiency as described in paragraph (4)(A).

"(2) CONSULTATION.—In preparing each report required under paragraph (1), the Secretary shall

consult with Indian tribes and tribal organizations (including those tribes or tribal organizations operating health care programs or facilities under any funding agreements entered into with the Service under the Indian Self-Determination and Education Assistance Act) to determine the sanitation needs of each tribe and in developing the criteria on which the needs will be evaluated through a process of negotiated rulemaking.

"(3) METHODOLOGY.—The methodology used by the Secretary in determining, preparing cost estimates for and reporting sanitation deficiencies for purposes of paragraph (1) shall be applied uniformly to all Indian tribes and communities.

"(4) SANITATION DEFICIENCY LEVELS.—For purposes of this subsection, the sanitation deficiency levels for an individual or community sanitation facility serving Indian homes are as follows:

"(A) A level I deficiency is a sanitation facility serving and individual or community—

"(i) which complies with all applicable water supply, pollution control and solid waste disposal laws; and

"(ii) in which the deficiencies relate to routine replacement, repair, or maintenance needs.

"(B) A level II deficiency is a sanitation facility serving and individual or community—

"(i) which substantially or recently complied with all applicable water supply, pollution control and solid waste laws, in which the deficiencies relate to small or minor capital improvements needed to bring the facility back into compliance;

"(ii) in which the deficiencies relate to capital improvements that are necessary to enlarge or improve the facilities in order to meet the current needs for domestic sanitation facilities; or

"(iii) in which the deficiencies relate to the lack of equipment or training by an Indian Tribe or community to properly operate and maintain the sanitation facilities.

"(C) A level III deficiency is an individual or community facility with water or sewer service in the home, piped services or a haul system with holding tanks and interior plumbing, or where major significant interruptions to water

supply or sewage disposal occur frequently, requiring major capital improvements to correct the deficiencies. There is no access to or no approved or permitted solid waste facility available.

"(D) A level IV deficiency is an individual or community facility where there are no piped water or sewer facilities in the home or the facility has become inoperable due to major component failure or where only a washeteria or central facility exists.

"(E) A level V deficiency is the absence of a sanitation facility, where individual homes do not have access to safe drinking water or adequate wastewater disposal.

"(i) DEFINITIONS.—In this section:

"(1) FACILITY.—The terms 'facility' or 'facilities' shall have the same meaning as the terms 'system' or 'systems' unless the context requires otherwise.

"(2) INDIAN COMMUNITY.—The term 'Indian community' means a geographic area, a significant proportion of whose inhabitants are Indians and which is served by or capable of being served by a facility described in this section.

"SEC. 303. PREFERENCE TO INDIANS AND INDIAN FIRMS.

"(a) IN GENERAL.—The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or any enterprise, partnership, corporation, or other type of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as an 'Indian firm') in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless the Secretary finds, pursuant to rules and regulations promulgated by the Secretary, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at such finding, shall consider whether the Indian or Indian firm will be deficient with respect to—

"(1) ownership and control by Indians;

"(2) equipment;

"(3) bookkeeping and accounting procedures;

"(4) substantive knowledge of the project or function to be contracted for;

"(5) adequately trained personnel; or

"(6) other necessary components of contract performance.

"(b) EXEMPTION FROM DAVIS-BACON.—For the purpose of implementing the provisions of this title, construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are exempt from the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act). For all health facilities, staff quarters and sanitation facilities, construction and renovation subcontractors shall be paid wages at rates that are not less than the prevailing wage rates for similar construction in the locality involved, as determined by the Indian tribe, Tribes, or tribal organizations served by such facilities.

"SEC. 304. SOBOBA SANITATION FACILITIES.

"Nothing in the Act of December 17, 1970 (84 Stat. 1465) shall be construed to preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat 674), as amended by the Act of July 31, 1959 (73 Stat. 267).

"SEC. 305. EXPENDITURE OF NONSERVICE FUNDS FOR RENOVATION.

"(a) PERMISSIBILITY.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized to accept any major expansion, renovation or modernization by any Indian tribe of any Service facility, or of any other Indian health facility operated pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act, including—

"(A) any plans or designs for such expansion, renovation or modernization; and

"(B) any expansion, renovation or modernization for which funds appropriated under any Federal law were lawfully expended;

but only if the requirements of subsection (b) are met.

"(2) PRIORITY LIST.—The Secretary shall maintain a separate priority list to address the need for increased operating expenses, personnel or equipment for such facilities described in paragraph (1). The methodology for establishing priorities shall be developed by negotiated rulemaking under section 802. The list of priority facilities will be revised annually in consultation with Indian tribes and tribal organizations.

"(3) REPORT.—The Secretary shall submit to the President, for inclusion in each report required to be transmitted to the Congress under section 801, the priority list maintained pursuant to paragraph (2).

"(b) REQUIREMENTS.—The requirements of this subsection are met with respect to any expansion, renovation or modernization if—

"(1) the tribe or tribal organization—

"(A) provides notice to the Secretary of its intent to expand, renovate or modernize; and

"(B) applies to the Secretary to be placed on a separate priority list to address the needs of such new facilities for increased operating expenses, personnel or equipment; and

"(2) the expansion renovation or modernization—

"(A) is approved by the appropriate area director of the Service for Federal facilities; and

"(B) is administered by the Indian tribe or tribal organization in accordance with any applicable regulations prescribed by the Secretary with respect to construction or renovation of Service facilities.

"(c) RIGHT OF TRIBE IN CASE OF FAILURE OF FACILITY TO BE USED AS A SERVICE FACILITY.—If any Service facility which has been expanded, renovated or modernized by an Indian tribe under this section ceases to be used as a Service facility during the 20-year period beginning on the date such expansion, renovation or modernization is completed, such Indian tribe shall be entitled to recover from the United States an amount which bears the same ratio to the value of such facility at the time of such cessation as the value of such expansion, renovation or modernization (less the total amount of any funds provided specifically for such facility under any Federal program that were expended for such expansion, renovation or modernization) bore to the value of such facility at the time of the completion of such expansion, renovation or modernization.

"SEC. 306. FUNDING FOR THE CONSTRUCTION, EXPANSION, AND MODERNIZATION OF SMALL AMBULATORY CARE FACILITIES.

"(a) AVAILABILITY OF FUNDING.—

"(1) IN GENERAL.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organization, shall make funding available to tribes and tribal organizations for the construction, expansion, or modernization of facili-

ties for the provision of ambulatory care services to eligible Indians (and noneligible persons as provided for in subsections (b)(2) and (c)(1)(C)). Funding under this section may cover up to 100 percent of the costs of such construction, expansion, or modernization. For the purposes of this section, the term 'construction' includes the replacement of an existing facility.

"(2) REQUIREMENT.—Funding under paragraph (1) may only be made available to an Indian tribe or tribal organization operating an Indian health facility (other than a facility owned or constructed by the Service, including a facility originally owned or constructed by the Service and transferred to an Indian tribe or tribal organization) pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

"(b) USE OF FUNDS.—

"(1) IN GENERAL.—Funds provided under this section may be used only for the construction, expansion, or modernization (including the planning and design of such construction, expansion, or modernization) of an ambulatory care facility—

"(A) located apart from a hospital;

"(B) not funded under section 301 or section 307; and

"(C) which, upon completion of such construction, expansion, or modernization will—

"(i) have a total capacity appropriate to its projected service population;

"(ii) provide annually not less than 500 patient visits by eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B); and

"(iii) provide ambulatory care in a service area (specified in the funding agreement entered into under the Indian Self-Determination and Education Assistance Act) with a population of not less than 1,500 eligible Indians and other users who are eligible for services in such facility in accordance with section 807(b)(1)(B).

"(2) LIMITATION.—Funding provided under this section may be used only for the cost of that portion of a construction, expansion or modernization project that benefits the service population described in clauses (ii) and (iii) of paragraph (1)(C). The requirements of such clauses (ii) and (iii) shall

not apply to a tribe or tribal organization applying for funding under this section whose principal office for health care administration is located on an island or where such office is not located on a road system providing direct access to an inpatient hospital where care is available to the service population.

"(c) APPLICATION AND PRIORITY.—

"(1) APPLICATION.—No funding may be made available under this section unless an application for such funding has been submitted to and approved by the Secretary. An application or proposal for funding under this section shall be submitted in accordance with applicable regulations and shall set forth reasonable assurance by the applicant that, at all times after the construction, expansion, or modernization of a facility carried out pursuant to funding received under this section—

"(A) adequate financial support will be available for the provision of services at such facility;

"(B) such facility will be available to eligible Indians without regard to ability to pay or source of payment; and

"(C) such facility will, as feasible without diminishing the quality or quantity of services

provided to eligible Indians, serve noneligible persons on a cost basis.

"(2) PRIORITY.—In awarding funds under this section, the Secretary shall give priority to tribes and tribal organizations that demonstrate—

"A) a need for increased ambulatory care services; and

"(B) insufficient capacity to deliver such services.

"(d) FAILURE TO USE FACILITY AS HEALTH FACILITY.—If any facility (or portion thereof) with respect to which funds have been paid under this section, ceases, within 5 years after completion of the construction, expansion, or modernization carried out with such funds, to be utilized for the purposes of providing health care services to eligible Indians, all of the right, title, and interest in and to such facility (or portion thereof) shall transfer to the United States unless otherwise negotiated by the Service and the Indian tribe or tribal organization.

"(e) NO INCLUSION IN TRIBAL SHARE.—Funding provided to Indian tribes and tribal organizations under this section shall be non-recurring and shall not be available for inclusion in any individual tribe's tribal share for an award under the Indian Self-Determination and Edu-

cation Assistance Act or for reallocation or redesign thereunder.

"SEC. 307. INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT.

"(a) HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.—The Secretary, acting through the Service and in consultation with Indian tribes and tribal organizations, may enter into funding agreements with, or make grants or loan guarantees to, Indian tribes or tribal organizations for the purpose of carrying out a health care delivery demonstration project to test alternative means of delivering health care and services through health facilities, including hospice, traditional Indian health and child care facilities, to Indians.

"(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

"(1) waive any leasing prohibition;

"(2) permit carryover of funds appropriated for the provision of health care services;

"(3) permit the use of other available funds;

"(4) permit the use of funds or property donated from any source for project purposes;

"(5) provide for the reversion of donated real or personal property to the donor; and

"(6) permit the use of Service funds to match other funds, including Federal funds.

"(c) CRITERIA.—

"(1) IN GENERAL.—The Secretary shall develop and publish regulations through rulemaking under section 802 for the review and approval of applications submitted under this section. The Secretary may enter into a contract, funding agreement or award a grant under this section for projects which meet the following criteria:

"(A) There is a need for a new facility or program or the reorientation of an existing facility or program.

"(B) A significant number of Indians, including those with low health status, will be served by the project.

"(C) The project has the potential to address the health needs of Indians in an innovative manner.

"(D) The project has the potential to deliver services in an efficient and effective manner.

"(E) The project is economically viable.

"(F) The Indian tribe or tribal organization has the administrative and financial capability to administer the project.

"(G) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

"(2) PEER REVIEW PANELS.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications and to advise the Secretary regarding such applications using the criteria developed pursuant to paragraph (1).

"(3) PRIORITY.—The Secretary shall give priority to applications for demonstration projects under this section in each of the following service units to the extent that such applications are filed in a timely manner and otherwise meet the criteria specified in paragraph (1):

"(A) Cass Lake, Minnesota.

"(B) Clinton, Oklahoma.

"(C) Harlem, Montana.

"(D) Mescalero, New Mexico.

"(E) Owyhee, Nevada.

"(F) Parker, Arizona.

"(G) Schurz, Nevada.

"(H) Winnebago, Nebraska.

"(I) Ft. Yuma, California

"(d) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

"(e) SERVICE TO INELIGIBLE PERSONS.—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health care practitioners as provided in section 807 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

"(f) EQUITABLE TREATMENT.—For purposes of subsection (c)(1)(A), the Secretary shall, in evaluating facilities operated under any funding agreement entered into with the Service under the Indian Self-Determination and Education Assistance Act, use the same criteria that the Secretary uses in evaluating facilities operated directly by the Service.

"(g) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation and expansion needs of Service and

non-Service facilities which are the subject of a funding agreement for health services entered into with the Service under the Indian Self-Determination and Education Assistance Act, are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

"SEC. 308. LAND TRANSFER.

"(a) GENERAL AUTHORITY FOR TRANSFERS.—Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

"(b) CHEMAWA INDIAN SCHOOL.—The Bureau of Indian Affairs is authorized to transfer, at no cost, up to 5 acres of land at the Chemawa Indian School, Salem, Oregon, to the Service for the provision of health care services. The land authorized to be transferred by this section is that land adjacent to land under the jurisdiction of the Service and occupied by the Chemawa Indian Health Center.

"SEC. 309. LEASES.

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary is authorized, in carrying out

the purposes of this Act, to enter into leases with Indian tribes and tribal organizations for periods not in excess of 20 years. Property leased by the Secretary from an Indian tribe or tribal organization may be reconstructed or renovated by the Secretary pursuant to an agreement with such Indian tribe or tribal organization.

"(b) FACILITIES FOR THE ADMINISTRATION AND DELIVERY OF HEALTH SERVICES.—The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold—

"(1) title to;

"(2) a leasehold interest in; or

"(3) a beneficial interest in (where title is held by the United States in trust for the benefit of a tribe);

facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations to compensate such Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes, and such leases shall be considered as operating leases for the purposes of scoring under the Budget Enforcement Act, notwithstanding any other provision of law. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and

maintenance expenses, and other expenses determined by regulation to be allowable pursuant to regulations under section 105(l) of the Indian Self-Determination and Education Assistance Act.

"SEC. 310. LOANS, LOAN GUARANTEES AND LOAN REPAYMENT.

"(a) HEALTH CARE FACILITIES LOAN FUND.—There is established in the Treasury of the United States a fund to be known as the 'Health Care Facilities Loan Fund' (referred to in this Act as the 'HCFLF') to provide to Indian Tribes and tribal organizations direct loans, or guarantees for loans, for the construction of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities such as behavioral health and elder care facilities).

"(b) STANDARDS AND PROCEDURES.—The Secretary may promulgate regulations, developed through rulemaking as provided for in section 802, to establish standards and procedures for governing loans and loan guarantees under this section, subject to the following conditions:

"(1) The principal amount of a loan or loan guarantee may cover up to 100 percent of eligible costs, including costs for the planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements,

medical equipment and furnishings, other facility related costs and capital purchase (but excluding staffing).

"(2) The cumulative total of the principal of direct loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriation Acts.

"(3) In the discretion of the Secretary, the program under this section may be administered by the Service or the Health Resources and Services Administration (which shall be specified by regulation).

"(4) The Secretary may make or guarantee a loan with a term of the useful estimated life of the facility, or 25 years, whichever is less.

"(5) The Secretary may allocate up to 100 percent of the funds available for loans or loan guarantees in any year for the purpose of planning and applying for a loan or loan guarantee.

"(6) The Secretary may accept an assignment of the revenue of an Indian tribe or tribal organization as security for any direct loan or loan guarantee under this section.

"(7) In the planning and design of health facilities under this section, users eligible under section

807(b) may be included in any projection of patient population.

"(8) The Secretary shall not collect loan application, processing or other similar fees from Indian tribes or tribal organizations applying for direct loans or loan guarantees under this section.

"(9) Service funds authorized under loans or loan guarantees under this section may be used in matching other Federal funds.

"(c) FUNDING.—

"(1) IN GENERAL.—The HCFLF shall consist of—

"(A) such sums as may be initially appropriated to the HCFLF and as may be subsequently appropriated under paragraph (2);

"(B) such amounts as may be collected from borrowers; and

"(C) all interest earned on amounts in the HCFLF.

"(2) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to initiate the HCFLF. For each fiscal year after the initial year in which funds are appropriated to the HCFLF, there is authorized to be appropriated an amount equal to the sum of the

amount collected by the HCFLF during the preceding fiscal year, and all accrued interest on such amounts.

"(3) AVAILABILITY OF FUNDS.—Amounts appropriated, collected or earned relative to the HCFLF shall remain available until expended.

"(d) FUNDING AGREEMENTS.—Amounts in the HCFLF and available pursuant to appropriation Acts may be expended by the Secretary, acting through the Service, to make loans under this section to an Indian tribe or tribal organization pursuant to a funding agreement entered into under the Indian Self-Determination and Education Assistance Act.

"(e) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the HCFLF as such Secretary determines are not required to meet current withdrawals from the HCFLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. Any obligation acquired by the fund may be sold by the Secretary of the Treasury at the market price.

"(f) GRANTS.—The Secretary is authorized to establish a program to provide grants to Indian tribes and trib-

al organizations for the purpose of repaying all or part of any loan obtained by an Indian tribe or tribal organization for construction and renovation of health care facilities (including inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities). Loans eligible for such repayment grants shall include loans that have been obtained under this section or otherwise.

"SEC. 311. TRIBAL LEASING.

"Indian Tribes and tribal organizations providing health care services pursuant to a funding agreement contract entered into under the Indian Self-Determination and Education Assistance Act may lease permanent structures for the purpose of providing such health care services without obtaining advance approval in appropriation Acts.

"SEC. 312. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

"(a) AUTHORITY.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian tribes and tribal organizations to establish joint venture demonstration projects under which an Indian tribe or tribal organization shall expend tribal, private, or other available funds, for the acquisi-

tion or construction of a health facility for a minimum of 10 years, under a no-cost lease, in exchange for agreement by the Service to provide the equipment, supplies, and staffing for the operation and maintenance of such a health facility.

"(2) USE OF RESOURCES.—A tribe or tribal organization may utilize tribal funds, private sector, or other available resources, including loan guarantees, to fulfill its commitment under this subsection.

"(3) ELIGIBILITY OF CERTAIN ENTITIES.—A tribe that has begun and substantially completed the process of acquisition or construction of a health facility shall be eligible to establish a joint venture project with the Service using such health facility.

"(b) REQUIREMENTS.—

"(1) IN GENERAL.—The Secretary shall enter into an arrangement under subsection (a)(1) with an Indian tribe or tribal organization only if—

"(A) the Secretary first determines that the Indian tribe or tribal organization has the administrative and financial capabilities necessary to complete the timely acquisition or construction of the health facility described in subsection (a)(1); and

"(B) the Indian tribe or tribal organization meets the needs criteria that shall be developed through the negotiated rulemaking process provided for under section 802.

"(2) CONTINUED OPERATION OF FACILITY.—The Secretary shall negotiate an agreement with the Indian tribe or tribal organization regarding the continued operation of a facility under this section at the end of the initial 10 year no-cost lease period.

"(3) BREACH OR TERMINATION OF AGREEMENT.—An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the tribe or tribal organization, or paid to a third party on the tribe's or tribal organization's behalf, under the agreement. The Secretary has the right to recover tangible property (including supplies), and equipment, less depreciation, and any funds expended for operations and maintenance under this section. The preceding sentence shall not apply to any funds expended for the delivery of health care services, or for personnel or staffing.

"(d) RECOVERY FOR NON-USE.—An Indian tribe or tribal organization that has entered into a written agreement with the Secretary under this section shall be entitled to recover from the United States an amount that is proportional to the value of such facility should at any time within 10 years the Service ceases to use the facility or otherwise breaches the agreement.

"(e) DEFINITION.—In this section, the terms 'health facility' or 'health facilities' include staff quarters needed to provide housing for the staff of the tribal health program.

"SEC. 313. LOCATION OF FACILITIES.

"(a) PRIORITY.—The Bureau of Indian Affairs and the Service shall, in all matters involving the reorganization or development of Service facilities, or in the establishment of related employment projects to address unemployment conditions in economically depressed areas, give priority to locating such facilities and projects on Indian lands if requested by the Indian owner and the Indian tribe with jurisdiction over such lands or other lands owned or leased by the Indian tribe or tribal organization so long as priority is given to Indian land owned by an Indian tribe or tribes.

"(b) DEFINITION.—In this section, the term 'Indian lands' means—

"(1) all lands within the exterior boundaries of any Indian reservation;

"(2) any lands title to which is held in trust by the United States for the benefit of any Indian tribe or individual Indian, or held by any Indian tribe or individual Indian subject to restriction by the United States against alienation and over which an Indian tribe exercises governmental power; and

"(3) all lands in Alaska owned by any Alaska Native village, or any village or regional corporation under the Alaska Native Claims Settlement Act, or any land allotted to any Alaska Native.

"SEC. 314. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

"(a) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be transmitted to Congress under section 801, a report that identifies the backlog of maintenance and repair work required at both Service and tribal facilities, including new facilities expected to be in operation in the fiscal year after the year for which the report is being prepared. The report shall identify the need for renovation and expansion of existing facilities to support the growth of health care programs.

"(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—

"(1) IN GENERAL.—The Secretary may expend maintenance and improvement funds to support the maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian tribe or tribal organization.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'supportable space allocation' shall be defined through the negotiated rulemaking process provided for under section 802.

"(c) CONSTRUCTION OF REPLACEMENT FACILITIES.—

"(1) IN GENERAL.—In addition to using maintenance and improvement funds for the maintenance of facilities under subsection (b)(1), an Indian tribe or tribal organization may use such funds for the construction of a replacement facility if the costs of the renovation of such facility would exceed a maximum renovation cost threshold.

"(2) DEFINITION.—For purposes of paragraph (1), the term 'maximum renovation cost threshold' shall be defined through the negotiated rulemaking process provided for under section 802.

"SEC. 315. TRIBAL MANAGEMENT OF FEDERALLY-OWNED QUARTERS.

"(a) ESTABLISHMENT OF RENTAL RATES.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, an Indian tribe or tribal organization which operates a hospital or other health facility and the Federally-owned quarters associated therewith, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, may establish the rental rates charged to the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

"(2) OBJECTIVES.—In establishing rental rates under paragraph (1), an Indian tribe or tribal organization shall attempt to achieve the following objectives:

"(A) The rental rates should be based on the reasonable value of the quarters to the occupants thereof.

"(B) The rental rates should generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and, subject to the discretion of the Indian tribe or tribal organization, to supply reserve funds for capital repairs and replacement of the quarters.

"(3) ELIGIBILITY FOR QUARTERS IMPROVEMENT AND REPAIR.—Any quarters whose rental

rates are established by an Indian tribe or tribal organization under this subsection shall continue to be eligible for quarters improvement and repair funds to the same extent as other Federally-owned quarters that are used to house personnel in Service-supported programs.

"(4) NOTICE OF CHANGE IN RATES.—An Indian tribe or tribal organization that exercises the authority provided under this subsection shall provide occupants with not less than 60 days notice of any change in rental rates.

"(b) COLLECTION OF RENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, and subject to paragraph (2), an Indian tribe or a tribal organization that operates Federally-owned quarters pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act shall have the authority to collect rents directly from Federal employees who occupy such quarters in accordance with the following:

"(A) The Indian tribe or tribal organization shall notify the Secretary and the Federal employees involved of its election to exercise its authority to collect rents directly from such Federal employees.

"(B) Upon the receipt of a notice described in subparagraph (A), the Federal employees involved shall pay rents for the occupancy of such quarters directly to the Indian tribe or tribal organization and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

"(C) Such rent payments shall be retained by the Indian tribe or tribal organization and shall not be made payable to or otherwise be deposited with the United States.

"(D) Such rent payments shall be deposited into a separate account which shall be used by the Indian tribe or tribal organization for the maintenance (including capital repairs and replacement expenses) and operation of the quarters and facilities as the Indian tribe or tribal organization shall determine appropriate.

"(2) RETROCESSION.—If an Indian tribe or tribal organization which has made an election under paragraph (1) requests retrocession of its authority to directly collect rents from Federal employees occupying Federally-owned quarters, such retrocession shall become effective on the earlier of—

"(A) the first day of the month that begins not less than 180 days after the Indian tribe or tribal organization notifies the Secretary of its desire to retrocede; or

"(B) such other date as may be mutually agreed upon by the Secretary and the Indian tribe or tribal organization.

"(c) RATES.—To the extent that an Indian tribe or tribal organization, pursuant to authority granted in subsection (a), establishes rental rates for Federally-owned quarters provided to a Federal employee in Alaska, such rents may be based on the cost of comparable private rental housing in the nearest established community with a year-round population of 1,500 or more individuals.–

"SEC. 316. APPLICABILITY OF BUY AMERICAN REQUIREMENT.

"(a) IN GENERAL.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to the authorization contained in section 318, except that Indian tribes and tribal organizations shall be exempt from such requirements.

"(b) FALSE OR MISLEADING LABELING.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a 'Made

in America' inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to the authorization contained in section 318, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

(c) DEFINITION.—In this section, the term 'Buy American Act' means title III of the Act entitled 'An Act making appropriations for the Treasury and Post Office Departments for the fiscal year ending June 30, 1934, and for other purposes', approved March 3, 1933 (41 U.S.C. 10a et seq.).

"SEC. 317. OTHER FUNDING FOR FACILITIES.

"Notwithstanding any other provision of law—

"(1) the Secretary may accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design and construct health care facilities for Indians and to place such funds into funding agreements authorized under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f et seq.) between the Secretary

and an Indian tribe or tribal organization, except that the receipt of such funds shall not have an effect on the priorities established pursuant to section 301;

"(2) the Secretary may enter into interagency agreements with other Federal or State agencies and other entities and to accept funds from such Federal or State agencies or other entities to provide for the planning, design and construction of health care facilities to be administered by the Service or by Indian tribes or tribal organizations under the Indian Self-Determination and Education Assistance Act in order to carry out the purposes of this Act, together with the purposes for which such funds are appropriated to such other Federal or State agency or for which the funds were otherwise provided;

"(3) any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency; and

"(4) the Secretary, acting through the Service, shall establish standards under regulations developed

through rulemaking under section 802, for the planning, design and construction of health care facilities serving Indians under this Act.

"SEC. 318. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE IV—ACCESS TO HEALTH SERVICES

"SEC. 401. TREATMENT OF PAYMENTS UNDER MEDICARE PROGRAM.

"(a) IN GENERAL.—Any payments received by the Service, by an Indian tribe or tribal organization pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization pursuant to title V of this Act for services provided to Indians eligible for benefits under title XVIII of the Social Security Act shall not be considered in determining appropriations for health care and services to Indians.

"(b) EQUAL TREATMENT.—Nothing in this Act authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act in preference to an Indian beneficiary without such coverage.

"(c) SPECIAL FUND.—

"(1) USE OF FUNDS.—Notwithstanding any other provision of this title or of title XVIII of the Social Security Act, payments to which any facility of the Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the programs of the Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of this title and of title XVIII of the Social Security Act. Any funds to be reimbursed which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes.

"(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for benefits under title XVIII of the Social Security Act.

"SEC. 402. TREATMENT OF PAYMENTS UNDER MEDICAID PROGRAM.

"(a) SPECIAL FUND.—

"(1) USE OF FUNDS.—Notwithstanding any other provision of law, payments to which any facility of the Service (including a hospital, nursing facility, intermediate care facility for the mentally retarded, or any other type of facility which provides services for which payment is available under title XIX of the Social Security Act) is entitled under a State plan by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and first used (to such extent or in such amounts as are provided in appropriation Acts) for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve or maintain compliance with the applicable conditions and requirements of such title. Any payments which are in excess of the amount necessary to achieve or maintain such conditions and requirements shall, subject to the consultation with tribes being served by the service unit, be used for reducing the health resource deficiencies of the Indian tribes. In making payments from such fund, the Secretary shall ensure that each service unit of the Service receives 100 percent of the amounts to which

the facilities of the Service, for which such service unit makes collections, are entitled by reason of section 1911 of the Social Security Act.

"(2) NONAPPLICATION IN CASE OF ELECTION FOR DIRECT BILLING.—Paragraph (1) shall not apply upon the election of an Indian tribe or tribal organization under section 405 to receive direct payments for services provided to Indians eligible for medical assistance under title XIX of the Social Security Act.

"(b) PAYMENTS DISREGARDED FOR APPROPRIATIONS.—Any payments received under section 1911 of the Social Security Act for services provided to Indians eligible for benefits under title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians.

"(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405.

"SEC. 403. REPORT.

"(a) INCLUSION IN ANNUAL REPORT.—The Secretary shall submit to the President, for inclusion in the

report required to be transmitted to the Congress under section 801, an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements under titles XVIII and XIX of the Social Security Act.

"(b) IDENTIFICATION OF SOURCE OF PAYMENTS.—If an Indian tribe or tribal organization receives funding from the Service under the Indian Self-Determination and Education Assistance Act or an urban Indian organization receives funding from the Service under Title V of this Act and receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act, such Indian tribe or tribal organization, or urban Indian organization, shall provide to the Service a list of each provider enrollment number (or other identifier) under which it receives such reimbursements or payments.

"SEC. 404. GRANTS TO AND FUNDING AGREEMENTS WITH THE SERVICE, INDIAN TRIBES OR TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary shall make grants to or enter into funding agreements with Indian tribes and tribal organizations to assist such organizations in establishing and administering programs on or near Federal In-

dian reservations and trust areas and in or near Alaska Native villages to assist individual Indians to—

"(1) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

"(2) pay premiums for health insurance coverage; and

"(3) apply for medical assistance provided pursuant to titles XIX and XXI of the Social Security Act.

"(b) CONDITIONS.—The Secretary shall place conditions as deemed necessary to effect the purpose of this section in any funding agreement or grant which the Secretary makes with any Indian tribe or tribal organization pursuant to this section. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake to—

"(1) determine the population of Indians to be served that are or could be recipients of benefits or assistance under titles XVIII, XIX, and XXI of the Social Security Act;

"(2) assist individual Indians in becoming familiar with and utilizing such benefits and assistance;

"(3) provide transportation to such individual Indians to the appropriate offices for enrollment or applications for such benefits and assistance;

"(4) develop and implement—

"(A) a schedule of income levels to determine the extent of payments of premiums by such organizations for health insurance coverage of needy individuals; and

"(B) methods of improving the participation of Indians in receiving the benefits and assistance provided under titles XVIII, XIX, and XXI of the Social Security Act.

"(c) AGREEMENTS FOR RECEIPT AND PROCESSING OF APPLICATIONS.—The Secretary may enter into an agreement with an Indian tribe or tribal organization, or an urban Indian organization, which provides for the receipt and processing of applications for medical assistance under title XIX of the Social Security Act, child health assistance under title XXI of such Act and benefits under title XVIII of such Act by a Service facility or a health care program administered by such Indian tribe or tribal organization, or urban Indian organization, pursuant to a funding agreement under the Indian Self-Determination and Education Assistance Act or a grant or contract entered into with an urban Indian organization under title

V of this Act. Notwithstanding any other provision of law, such agreements shall provide for reimbursement of the cost of outreach, education regarding eligibility and benefits, and translation when such services are provided. The reimbursement may be included in an encounter rate or be made on a fee-for-service basis as appropriate for the provider. When necessary to carry out the terms of this section, the Secretary, acting through the Health Care Financing Administration or the Service, may enter into agreements with a State (or political subdivision thereof) to facilitate cooperation between the State and the Service, an Indian tribe or tribal organization, and an urban Indian organization.

"(d) GRANTS.—

"(1) IN GENERAL.—The Secretary shall make grants or enter into contracts with urban Indian organizations to assist such organizations in establishing and administering programs to assist individual urban Indians to—

"(A) enroll under sections 1818, 1836, and 1837 of the Social Security Act;

"(B) pay premiums on behalf of such individuals for coverage under title XVIII of such Act; and

"(C) apply for medical assistance provided under title XIX of such Act and for child health assistance under title XXI of such Act.

"(2) REQUIREMENTS.—The Secretary shall include in the grants or contracts made or entered into under paragraph (1) requirements that are—

"(A) consistent with the conditions imposed by the Secretary under subsection (b);

"(B) appropriate to urban Indian organizations and urban Indians; and

"(C) necessary to carry out the purposes of this section.

"SEC. 405. DIRECT BILLING AND REIMBURSEMENT OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS.

"(a) DIRECT BILLING.—

"(1) IN GENERAL.—An Indian tribe or tribal organization may directly bill for, and receive payment for, health care services provided by such tribe or organization for which payment is made under title XVIII of the Social Security Act, under a State plan for medical assistance approved under title XIX of such Act, under a State child health plan approved under title XXI of such Act, or from any other third party payor.

"(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social Security Act and section 2101(c) of such Act shall apply for purposes of reimbursement under the medicaid or State children's health insurance program for health care services directly billed under the program established under this section.

"(b) DIRECT REIMBURSEMENT.—

"(1) USE OF FUNDS.—Each Indian tribe or tribal organization exercising the option described in subsection (a) of this section shall be reimbursed directly under the medicare, medicaid, and State children's health insurance programs for services furnished, without regard to the provisions of sections 1880(c) of the Social Security Act and section 402(a) of this Act, but all funds so reimbursed shall first be used by the health program for the purpose of making any improvements in the facility or health programs that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to such health services under the medicare, medicaid, or State children's health insurance program. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions or requirements

shall be used to provide additional health services, improvements in its health care facilities, or otherwise to achieve the health objectives provided for under section 3 of this Act.

"(2) AUDITS.—The amounts paid to the health programs exercising the option described in subsection (a) shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare, medicaid, and State children's health insurance programs.

"(3) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 401(c) or section 402(a), no payment may be made out of the special fund described in section 401(c) or 402(a), for the benefit of any health program exercising the option described in subsection (a) of this section during the period of such participation.

"(c) EXAMINATION AND IMPLEMENTATION OF CHANGES.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section,

including any agreements with States that may be necessary to provide for direct billing under the medicaid or State children's health insurance program.

"(d) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that an Indian tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination and Education Assistance Act. All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.

"(e) LIMITATION.—Notwithstanding this section, absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), neither the United States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the in-

jury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service may receive and expend such funds for the provision of additional health services.

"SEC. 406. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

"(a) RIGHT OF RECOVERY.—Except as provided in subsection (g), the United States, an Indian tribe or tribal organization shall have the right to recover the reasonable charges billed or expenses incurred by the Secretary or an Indian tribe or tribal organization in providing health services, through the Service or an Indian tribe or tribal organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if—

"(1) such services had been provided by a nongovernmental provider; and

"(2) such individual had been required to pay such charges or expenses and did pay such expenses.

"(b) URBAN INDIAN ORGANIZATIONS.—Except as provided in subsection (g), an urban Indian organization shall have the right to recover the reasonable charges

billed or expenses incurred by the organization in providing health services to any individual to the same extent that such individual, or any other nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such charges or expenses if such individual had been required to pay such charges or expenses and did pay such charges or expenses.

"(c) LIMITATIONS ON RECOVERIES FROM STATES.—Subsections (a) and (b) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

"(1) workers' compensation laws; or

"(2) a no-fault automobile accident insurance plan or program.

"(d) NONAPPLICATION OF OTHER LAWS.—No law of any State, or of any political subdivision of a State and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder the right of recovery of the United States or an Indian tribe or tribal organization under subsection (a), or an urban Indian organization under subsection (b).

"(e) NO EFFECT ON PRIVATE RIGHTS OF ACTION.—No action taken by the United States or an Indian tribe or tribal organization to enforce the right of recovery pro-

vided under subsection (a), or by an urban Indian organization to enforce the right of recovery provided under subsection (b), shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

"(f) METHODS OF ENFORCEMENT.—

"(1) IN GENERAL.—The United States or an Indian tribe or tribal organization may enforce the right of recovery provided under subsection (a), and an urban Indian organization may enforce the right of recovery provided under subsection (b), by—

"(A) intervening or joining in any civil action or proceeding brought—

"(i) by the individual for whom health services were provided by the Secretary, an Indian tribe or tribal organization, or urban Indian organization; or

"(ii) by any representative or heirs of such individual; or

"(B) instituting a civil action.

"(2) NOTICE.—All reasonable efforts shall be made to provide notice of an action instituted in accordance with paragraph (1)(B) to the individual to whom health services were provided, either before or during the pendency of such action.

"(g) LIMITATION.—Notwithstanding this section, absent specific written authorization by the governing body of an Indian tribe for the period of such authorization (which may not be for a period of more than 1 year and which may be revoked at any time upon written notice by the governing body to the Service), neither the United States through the Service, nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, nor an urban Indian organization funded under title V, shall have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Where such tribal authorization is provided, the Service may receive and expend such funds for the provision of additional health services.

"(h) COSTS AND ATTORNEYS' FEES.—In any action brought to enforce the provisions of this section, a prevailing plaintiff shall be awarded reasonable attorneys' fees and costs of litigation.

"(i) RIGHT OF ACTION AGAINST INSURERS AND EMPLOYEE BENEFIT PLANS.—

"(1) IN GENERAL.—Where an insurance company or employee benefit plan fails or refuses to pay

the amount due under subsection (a) for services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the United States or an Indian tribe or tribal organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal, State or tribal law.

"(2) URBAN INDIAN ORGANIZATIONS.—Where an insurance company or employee benefit plan fails or refuses to pay the amounts due under subsection (b) for health services provided to an individual who is a beneficiary, participant, or insured of such company or plan, the urban Indian organization shall have a right to assert and pursue all the claims and remedies against such company or plan, and against the fiduciaries of such company or plan, that the individual could assert or pursue under applicable Federal or State law.

"(j) NONAPPLICATION OF CLAIMS FILING REQUIREMENTS.—Notwithstanding any other provision in law, the Service, an Indian tribe or tribal organization, or an urban Indian organization shall have a right of recovery for any otherwise reimbursable claim filed on a current HCFA-

1500 or UB–92 form, or the current NSF electronic format, or their successors. No health plan shall deny payment because a claim has not been submitted in a unique format that differs from such forms.

"SEC. 407. CREDITING OF REIMBURSEMENTS.

"(a) RETENTION OF FUNDS.—Except as provided in section 202(d), this title, and section 807, all reimbursements received or recovered under the authority of this Act, Public Law 87–693, or any other provision of law, by reason of the provision of health services by the Service or by an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, or by an urban Indian organization funded under title V, shall be retained by the Service or that tribe or tribal organization and shall be available for the facilities, and to carry out the programs, of the Service or that tribe or tribal organization to provide health care services to Indians.

"(b) NO OFFSET OF FUNDS.—The Service may not offset or limit the amount of funds obligated to any service unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

"SEC. 408. PURCHASING HEALTH CARE COVERAGE.

"An Indian tribe or tribal organization, and an urban Indian organization may utilize funding from the Sec-

retary under this Act to purchase managed care coverage for Service beneficiaries (including insurance to limit the financial risks of managed care entities) from—

"(1) a tribally owned and operated managed care plan;

"(2) a State or locally-authorized or licensed managed care plan; or

"(3) a health insurance provider.

"SEC. 409. INDIAN HEALTH SERVICE, DEPARTMENT OF VETERAN'S AFFAIRS, AND OTHER FEDERAL AGENCY HEALTH FACILITIES AND SERVICES SHARING.

"(a) EXAMINATION OF FEASIBILITY OF ARRANGEMENTS.—

"(1) IN GENERAL.—The Secretary shall examine the feasibility of entering into arrangements or expanding existing arrangements for the sharing of medical facilities and services between the Service and the Veterans' Administration, and other appropriate Federal agencies, including those within the Department, and shall, in accordance with subsection (b), prepare a report on the feasibility of such arrangements.

"(2) SUBMISSION OF REPORT.—Not later than September 30, 2000, the Secretary shall submit the report required under paragraph (1) to Congress.

"(3) CONSULTATION REQUIRED.—The Secretary may not finalize any arrangement described in paragraph (1) without first consulting with the affected Indian tribes.

"(b) LIMITATIONS.—The Secretary shall not take any action under this section or under subchapter IV of chapter 81 of title 38, United States Code, which would impair—

"(1) the priority access of any Indian to health care services provided through the Service;

"(2) the quality of health care services provided to any Indian through the Service;

"(3) the priority access of any veteran to health care services provided by the Veterans' Administration;

"(4) the quality of health care services provided to any veteran by the Veteran's Administration;

"(5) the eligibility of any Indian to receive health services through the Service; or

"(6) the eligibility of any Indian who is a veteran to receive health services through the Veterans' Administration provided, however, the Service or the

Indian tribe or tribal organization shall be reimbursed by the Veterans' Administration where services are provided through the Service or Indian tribes or tribal organizations to beneficiaries eligible for services from the Veterans' Administration, notwithstanding any other provision of law.

"(c) AGREEMENTS FOR PARITY IN SERVICES.—The Service may enter into agreements with other Federal agencies to assist in achieving parity in services for Indians. Nothing in this section may be construed as creating any right of a veteran to obtain health services from the Service.

"SEC. 410. PAYOR OF LAST RESORT.

"The Service, and programs operated by Indian tribes or tribal organizations, or urban Indian organizations shall be the payor of last resort for services provided to individuals eligible for services from the Service and such programs, notwithstanding any Federal, State or local law to the contrary, unless such law explicitly provides otherwise.

"SEC. 411. RIGHT TO RECOVER FROM FEDERAL HEALTH CARE PROGRAMS.

"Notwithstanding any other provision of law, the Service, Indian tribes or tribal organizations, and urban Indian organizations (notwithstanding limitations on who

is eligible to receive services from such entities) shall be entitled to receive payment or reimbursement for services provided by such entities from any Federally funded health care program, unless there is an explicit prohibition on such payments in the applicable authorizing statute.

"SEC. 412. TUBA CITY DEMONSTRATION PROJECT.

"(a) IN GENERAL.—Notwithstanding any other provision of law, including the Anti-Deficiency Act, provided the Indian tribes to be served approve, the Service in the Tuba City Service Unit may—

"(1) enter into a demonstration project with the State of Arizona under which the Service would provide certain specified medicaid services to individuals dually eligible for services from the Service and for medical assistance under title XIX of the Social Security Act in return for payment on a capitated basis from the State of Arizona; and

"(2) purchase insurance to limit the financial risks under the project.

"(b) EXTENSION OF PROJECT.—The demonstration project authorized under subsection (a) may be extended to other service units in Arizona, subject to the approval of the Indian tribes to be served in such service units, the Service, and the State of Arizona.

"SEC. 413. ACCESS TO FEDERAL INSURANCE.

"Notwithstanding the provisions of title 5, United States Code, Executive Order, or administrative regulation, an Indian tribe or tribal organization carrying out programs under the Indian Self-Determination and Education Assistance Act or an urban Indian organization carrying out programs under title V of this Act shall be entitled to purchase coverage, rights and benefits for the employees of such Indian tribe or tribal organization, or urban Indian organization, under chapter 89 of title 5, United States Code, and chapter 87 of such title if necessary employee deductions and agency contributions in payment for the coverage, rights, and benefits for the period of employment with such Indian tribe or tribal organization, or urban Indian organization, are currently deposited in the applicable Employee's Fund under such title.

"SEC. 414. CONSULTATION AND RULEMAKING.

"(a) CONSULTATION.—Prior to the adoption of any policy or regulation by the Health Care Financing Administration, the Secretary shall require the Administrator of that Administration to—

"(1) identify the impact such policy or regulation may have on the Service, Indian tribes or tribal organizations, and urban Indian organizations;

"(2) provide to the Service, Indian tribes or tribal organizations, and urban Indian organizations the information described in paragraph (1);

"(3) engage in consultation, consistent with the requirements of Executive Order 13084 of May 14, 1998, with the Service, Indian tribes or tribal organizations, and urban Indian organizations prior to enacting any such policy or regulation.

"(b) RULEMAKING.—The Administrator of the Health Care Financing Administration shall participate in the negotiated rulemaking provided for under title VIII with regard to any regulations necessary to implement the provisions of this title that relate to the Social Security Act.

"SEC. 415. LIMITATIONS ON CHARGES.

"No provider of health services that is eligible to receive payments or reimbursements under titles XVIII, XIX, or XXI of the Social Security Act or from any Federally funded (whether in whole or part) health care program may seek to recover payment for services—

"(1) that are covered under and furnished to an individual eligible for the contract health services program operated by the Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an

urban Indian organization, in an amount in excess of the lowest amount paid by any other payor for comparable services; or

"(2) for examinations or other diagnostic procedures that are not medically necessary if such procedures have already been performed by the referring Indian health program and reported to the provider.

"SEC. 416. LIMITATION ON SECRETARY'S WAIVER AUTHORITY.

"Notwithstanding any other provision of law, the Secretary may not waive the application of section 1902(a)(13)(D) of the Social Security Act to any State plan under title XIX of the Social Security Act.

"SEC. 417. WAIVER OF MEDICARE AND MEDICAID SANCTIONS.

"Notwithstanding any other provision of law, the Service or an Indian tribe or tribal organization or an urban Indian organization operating a health program under the Indian Self-Determination and Education Assistance Act shall be entitled to seek a waiver of sanctions imposed under title XVIII, XIX, or XXI of the Social Security Act as if such entity were directly responsible for administering the State health care program.

"SEC. 418. MEANING OF 'REMUNERATION' FOR PURPOSES OF SAFE HARBOR PROVISIONS; ANTITRUST IMMUNITY.

"(a) MEANING OF REMUNERATION.—Notwithstanding any other provision of law, the term 'remuneration' as used in sections 1128A and 1128B of the Social Security Act shall not include any exchange of anything of value between or among—

"(1) any Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act;

"(2) any such Indian tribe or tribal organization or urban Indian organization and the Service;

"(3) any such Indian tribe or tribal organization or urban Indian organization and any patient served or eligible for service under such programs, including patients served or eligible for service pursuant to section 813 of this Act (as in effect on the day before the date of enactment of the Indian Health Care Improvement Act Reauthorization of 2000); or

"(4) any such Indian tribe or tribal organization or urban Indian organization and any third party required by contract, section 206 or 207 of this Act (as so in effect), or other applicable law, to

pay or reimburse the reasonable health care costs incurred by the United States or any such Indian tribe or tribal organization or urban Indian organization; provided the exchange arises from or relates to such health programs.

"(b) ANTITRUST IMMUNITY.—An Indian tribe or tribal organization or an urban Indian organization that administers health programs under the authority of the Indian Self-Determination and Education Assistance Act or title V shall be deemed to be an agency of the United States and immune from liability under the Acts commonly known as the Sherman Act, the Clayton Act, the Robinson-Patman Anti-Discrimination Act, the Federal Trade Commission Act, and any other Federal, State, or local antitrust laws, with regard to any transaction, agreement, or conduct that relates to such programs.

"SEC. 419. CO-INSURANCE, CO-PAYMENTS, DEDUCTIBLES AND PREMIUMS.

"(a) EXEMPTION FROM COST-SHARING REQUIREMENTS.—Notwithstanding any other provision of Federal or State law, no Indian who is eligible for services under title XVIII, XIX, or XXI of the Social Security Act, or under any other Federally funded health care programs, may be charged a deductible, co-payment, or co-insurance for any service provided by or through the Service, an In-

dian tribe or tribal organization or urban Indian organization, nor may the payment or reimbursement due to the Service or an Indian tribe or tribal organization or urban Indian organization be reduced by the amount of the deductible, co-payment, or co-insurance that would be due from the Indian but for the operation of this section. For the purposes of this section, the term 'through' shall include services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian tribe or tribal organization or an urban Indian organization and another health provider.

"(b) EXEMPTION FROM PREMIUMS.—

"(1) MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.—Notwithstanding any other provision of Federal or State law, no Indian who is otherwise eligible for medical assistance under title XIX of the Social Security Act or child health assistance under title XXI of such Act may be charged a premium as a condition of receiving such assistance under title XIX of XXI of such Act.

"(2) MEDICARE ENROLLMENT PREMIUM PENALTIES.—Notwithstanding section 1839(b) of the Social Security Act or any other provision of Federal or State law, no Indian who is eligible for benefits under part B of title XVIII of the Social Security

Act, but for the payment of premiums, shall be charged a penalty for enrolling in such part at a time later than the Indian might otherwise have been first eligible to do so. The preceding sentence applies whether an Indian pays for premiums under such part directly or such premiums are paid by another person or entity, including a State, the Service, an Indian Tribe or tribal organization, or an urban Indian organization.

"SEC. 420. INCLUSION OF INCOME AND RESOURCES FOR PURPOSES OF MEDICALLY NEEDY MEDICAID ELIGIBILITY.

"For the purpose of determining the eligibility under section 1902(a)(10)(A)(ii)(IV) of the Social Security Act of an Indian for medical assistance under a State plan under title XIX of such Act, the cost of providing services to an Indian in a health program of the Service, an Indian Tribe or tribal organization, or an urban Indian organization shall be deemed to have been an expenditure for health care by the Indian.

"SEC. 421. ESTATE RECOVERY PROVISIONS.

"Notwithstanding any other provision of Federal or State law, the following property may not be included when determining eligibility for services or implementing estate recovery rights under title XVIII, XIX, or XXI of

the Social Security Act, or any other health care programs funded in whole or part with Federal funds:

"(1) Income derived from rents, leases, or royalties of property held in trust for individuals by the Federal Government.

"(2) Income derived from rents, leases, royalties, or natural resources (including timber and fishing activities) resulting from the exercise of federally protected rights, whether collected by an individual or a tribal group and distributed to individuals.

"(3) Property, including interests in real property currently or formerly held in trust by the Federal Government which is protected under applicable Federal, State or tribal law or custom from recourse, including public domain allotments.

"(4) Property that has unique religious or cultural significance or that supports subsistence or traditional life style according to applicable tribal law or custom.

"SEC. 422. MEDICAL CHILD SUPPORT.

"Notwithstanding any other provision of law, a parent shall not be responsible for reimbursing the Federal Government or a State for the cost of medical services provided to a child by or through the Service, an Indian tribe or tribal organization or an urban Indian organization.

For the purposes of this subsection, the term 'through' includes services provided directly, by referral, or under contracts or other arrangements between the Service, an Indian Tribe or tribal organization or an urban Indian organization and another health provider.

"SEC. 423. PROVISIONS RELATING TO MANAGED CARE.

"(a) RECOVERY FROM MANAGED CARE PLANS.—Notwithstanding any other provision in law, the Service, an Indian Tribe or tribal organization or an urban Indian organization shall have a right of recovery under section 408 from all private and public health plans or programs, including the medicare, medicaid, and State children's health insurance programs under titles XVIII, XIX, and XXI of the Social Security Act, for the reasonable costs of delivering health services to Indians entitled to receive services from the Service, an Indian Tribe or tribal organization or an urban Indian organization.

"(b) LIMITATION.—No provision of law or regulation, or of any contract, may be relied upon or interpreted to deny or reduce payments otherwise due under subsection (a), except to the extent the Service, an Indian tribe or tribal organization, or an urban Indian organization has entered into an agreement with a managed care entity regarding services to be provided to Indians or rates to be paid for such services, provided that such an agreement

may not be made a prerequisite for such payments to be made.

"(c) PARITY.—Payments due under subsection (a) from a managed care entity may not be paid at a rate that is less than the rate paid to a 'preferred provider' by the entity or, in the event there is no such rate, the usual and customary fee for equivalent services.

"(d) NO CLAIM REQUIREMENT.—A managed care entity may not deny payment under subsection (a) because an enrollee with the entity has not submitted a claim.

"(e) DIRECT BILLING.—Notwithstanding the preceding subsections of this section, the Service, an Indian tribe or tribal organization, or an urban Indian organization that provides a health service to an Indian entitled to medical assistance under the State plan under title XIX of the Social Security Act or enrolled in a child health plan under title XXI of such Act shall have the right to be paid directly by the State agency administering such plans notwithstanding any agreements the State may have entered into with managed care organizations or providers.

"(f) REQUIREMENT FOR MEDICAID MANAGED CARE ENTITIES.—A managed care entity (as defined in section 1932(a)(1)(B) of the Social Security Act shall, as a condition of participation in the State plan under title XIX of such Act, offer a contract to health programs administered

by the Service, an Indian tribe or tribal organization or an urban Indian organization that provides health services in the geographic area served by the managed care entity and such contract (or other provider participation agreement) shall contain terms and conditions of participation and payment no more restrictive or onerous than those provided for in this section.

"(g) PROHIBITION.—Notwithstanding any other provision of law or any waiver granted by the Secretary no Indian may be assigned automatically or by default under any managed care entity participating in a State plan under title XIX or XXI of the Social Security Act unless the Indian had the option of enrolling in a managed care plan or health program administered by the Service, an Indian tribe or tribal organization, or an urban Indian organization.

"(h) INDIAN MANAGED CARE PLANS.—Notwithstanding any other provision of law, any State entering into agreements with one or more managed care organizations to provide services under title XIX or XXI of the Social Security Act shall enter into such an agreement with the Service, an Indian tribe or tribal organization or an urban Indian organization under which such an entity may provide services to Indians who may be eligible or required to enroll with a managed care organization

through enrollment in an Indian managed care organization that provides services similar to those offered by other managed care organizations in the State. The Secretary and the State are hereby authorized to waive requirements regarding discrimination, capitalization, and other matters that might otherwise prevent an Indian managed care organization or health program from meeting Federal or State standards applicable to such organizations, provided such Indian managed care organization or health program offers Indian enrollees services of an equivalent quality to that required of other managed care organizations.

"(i) ADVERTISING.—A managed care organization entering into a contract to provide services to Indians on or near an Indian reservation shall provide a certificate of coverage or similar type of document that is written in the Indian language of the majority of the Indian population residing on such reservation.

"SEC. 424. NAVAJO NATION MEDICAID AGENCY.

"(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary may treat the Navajo Nation as a State under title XIX of the Social Security Act for purposes of providing medical assistance to Indians living within the boundaries of the Navajo Nation.

"(b) ASSIGNMENT AND PAYMENT.—Notwithstanding any other provision of law, the Secretary may assign and

pay all expenditures related to the provision of services to Indians living within the boundaries of the Navajo Nation under title XIX of the Social Security Act (including administrative expenditures) that are currently paid to or would otherwise be paid to the States of Arizona, New Mexico, and Utah, to an entity established by the Navajo Nation and approved by the Secretary, which shall be denominated the Navajo Nation Medicaid Agency.

"(c) AUTHORITY.—The Navajo Nation Medicaid Agency shall serve Indians living within the boundaries of the Navajo Nation and shall have the same authority and perform the same functions as other State agency responsible for the administration of the State plan under title XIX of the Social Security Act.

"(d) TECHNICAL ASSISTANCE.—The Secretary may directly assist the Navajo Nation in the development and implementation of a Navajo Nation Medicaid Agency for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act (which shall, for purposes of reimbursement to such Nation, include Western and traditional Navajo healing services) within the Navajo Nation. Such assistance may include providing funds for demonstration projects conducted with such Nation.

"(e) FMAP.—Notwithstanding section 1905(b) of the Social Security Act, the Federal medical assistance percentage shall be 100 per cent with respect to amounts the Navajo Nation Medicaid agency expends for medical assistance and related administrative costs.

"(f) WAIVER AUTHORITY.—The Secretary shall have the authority to waive applicable provisions of Title XIX of the Social Security Act to establish, develop and implement the Navajo Nation Medicaid Agency.

"(g) SCHIP.—At the option of the Navajo Nation, the Secretary may treat the Navajo Nation as a State for purposes of title XXI of the Social Security Act under terms equivalent to those described in the preceding subsections of this section.

"SEC. 425. INDIAN ADVISORY COMMITTEES.

"(a) NATIONAL INDIAN TECHNICAL ADVISORY GROUP.—The Administrator of the Health Care Financing Administration shall establish and fund the expenses of a National Indian Technical Advisory Group which shall have no fewer than 14 members, including at least 1 member designated by the Indian tribes and tribal organizations in each service area, 1 urban Indian organization representative, and 1 member representing the Service. The scope of the activities of such group shall be established under section 802 provided that such scope shall

include providing comment on and advice regarding the programs funded under titles XVIII, XIX, and XXI of the Social Security Act or regarding any other health care program funded (in whole or part) by the Health Care Financing Administration.

"(b) INDIAN MEDICAID ADVISORY COMMITTEES.—The Administrator of the Health Care Financing Administration shall establish and provide funding for a Indian Medicaid Advisory Committee made up of designees of the Service, Indian tribes and tribal organizations and urban Indian organizations in each State in which the Service directly operates a health program or in which there is one or more Indian tribe or tribal organization or urban Indian organization.

"SEC. 426. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title.".

"TITLE V—HEALTH SERVICES FOR URBAN INDIANS

"SEC. 501. PURPOSE.

"The purpose of this title is to establish programs in urban centers to make health services more accessible and available to urban Indians.

"SEC. 502. CONTRACTS WITH, AND GRANTS TO, URBAN INDIAN ORGANIZATIONS.

"Under the authority of the Act of November 2, 1921 (25 U.S.C. 13)(commonly known as the Snyder Act), the Secretary, through the Service, shall enter into contracts with, or make grants to, urban Indian organizations to assist such organizations in the establishment and administration, within urban centers, of programs which meet the requirements set forth in this title. The Secretary, through the Service, subject to section 506, shall include such conditions as the Secretary considers necessary to effect the purpose of this title in any contract which the Secretary enters into with, or in any grant the Secretary makes to, any urban Indian organization pursuant to this title.

"SEC. 503. CONTRACTS AND GRANTS FOR THE PROVISION OF HEALTH CARE AND REFERRAL SERVICES.

"(a) AUTHORITY.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, shall enter into contracts with, and make grants to, urban Indian organizations for the provision of health care and referral services for urban Indians. Any such contract or grant shall include requirements that the urban Indian organization successfully undertake to—

"(1) estimate the population of urban Indians residing in the urban center or centers that the organization proposes to serve who are or could be recipients of health care or referral services;

"(2) estimate the current health status of urban Indians residing in such urban center or centers;

"(3) estimate the current health care needs of urban Indians residing in such urban center or centers;

"(4) provide basic health education, including health promotion and disease prevention education, to urban Indians;

"(5) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians; and

"(6) where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians.

"(b) CRITERIA.—The Secretary, acting through the Service, shall by regulation adopted pursuant to section 520 prescribe the criteria for selecting urban Indian organizations to enter into contracts or receive grants under

this section. Such criteria shall, among other factors, include—

"(1) the extent of unmet health care needs of urban Indians in the urban center or centers involved;

"(2) the size of the urban Indian population in the urban center or centers involved;

"(3) the extent, if any, to which the activities set forth in subsection (a) would duplicate any project funded under this title;

"(4) the capability of an urban Indian organization to perform the activities set forth in subsection (a) and to enter into a contract with the Secretary or to meet the requirements for receiving a grant under this section;

"(5) the satisfactory performance and successful completion by an urban Indian organization of other contracts with the Secretary under this title;

"(6) the appropriateness and likely effectiveness of conducting the activities set forth in subsection (a) in an urban center or centers; and

"(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other agencies.

"(c) HEALTH PROMOTION AND DISEASE PREVENTION.—The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services for urban Indians through grants made to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a).

"(d) IMMUNIZATION SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, immunization services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(3) DEFINITION.—In this section, the term 'immunization services' means services to provide without charge immunizations against vaccine-preventable diseases.

"(e) MENTAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to urban Indian organizations administering contracts entered into, or receiving grants, under this section.

"(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment of the mental health needs of the urban Indian population concerned, the mental health services and other related resources available to that population, the barriers to obtaining those services and resources, and the needs that are unmet by such services and resources.

"(3) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) to provide outreach, educational, and referral services to urban Indians regarding the availability of direct behavioral health services, to educate urban Indians about behavioral health issues and services, and effect coordination with existing behavioral health providers in order to improve services to urban Indians;

"(C) to provide outpatient behavioral health services to urban Indians, including the identification and assessment of illness, therapeutic treatments, case management, support

groups, family treatment, and other treatment; and

"(D) to develop innovative behavioral health service delivery models which incorporate Indian cultural support systems and resources.

"(f) CHILD ABUSE.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to urban Indian organizations administering contracts entered into pursuant to this section or receiving grants under subsection (a) to prevent and treat child abuse (including sexual abuse) among urban Indians.

"(2) ASSESSMENT.—A grant may not be made under this subsection to an urban Indian organization until that organization has prepared, and the Service has approved, an assessment that documents the prevalence of child abuse in the urban Indian population concerned and specifies the services and programs (which may not duplicate existing services and programs) for which the grant is requested.

"(3) USE OF FUNDS.—Grants may be made under this subsection—

"(A) to prepare assessments required under paragraph (2);

"(B) for the development of prevention, training, and education programs for urban Indian populations, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

"(C) to provide direct outpatient treatment services (including individual treatment, family treatment, group therapy, and support groups) to urban Indians who are child victims of abuse (including sexual abuse) or adult survivors of child sexual abuse, to the families of such child victims, and to urban Indian perpetrators of child abuse (including sexual abuse).

"(4) CONSIDERATIONS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

"(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child

Welfare Act of 1978 (25 U.S.C. 1901 et seq.), if any;

"(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

"(C) the assessment required under paragraph (2).

"(g) MULTIPLE URBAN CENTERS.—The Secretary, acting through the Service, may enter into a contract with, or make grants to, an urban Indian organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to urban Indians in more than one urban center.

"SEC. 504. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

"(a) AUTHORITY.—

"(1) IN GENERAL.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary, acting through the Service, may enter into contracts with, or make grants to, urban Indian organizations situated in urban centers for which contracts have not been entered into, or grants have not been made, under section 503.

"(2) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the matters described in subsection (b)(1) in order to assist the Secretary in assessing the health status and health care needs of urban Indians in the urban center involved and determining whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization which the Secretary has entered into a contract with, or made a grant to, under this section.

"(b) REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

"(1) the urban Indian organization successfully undertake to—

"(A) document the health care status and unmet health care needs of urban Indians in the urban center involved; and

"(B) with respect to urban Indians in the urban center involved, determine the matters described in paragraphs (2), (3), (4), and (7) of section 503(b); and

"(2) the urban Indian organization complete performance of the contract, or carry out the re-

quirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable.

"(c) LIMITATION ON RENEWAL.—The Secretary may not renew any contract entered into, or grant made, under this section.

"SEC. 505. EVALUATIONS; RENEWALS.

"(a) PROCEDURES.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements under this title and compliance with, and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

"(b) COMPLIANCE WITH TERMS.—The Secretary, acting through the Service, shall evaluate the compliance of each urban Indian organization which has entered into a contract or received a grant under section 503 with the terms of such contract of grant. For purposes of an evaluation under this subsection, the Secretary, in determining the capacity of an urban Indian organization to deliver quality patient care shall, at the option of the organization—

"(1) conduct, through the Service, an annual onsite evaluation of the organization; or

"(2) accept, in lieu of an onsite evaluation, evidence of the organization's provisional or full accreditation by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers participating in the medicare program under Title XVIII of the Social Security Act.

"(c) NONCOMPLIANCE.—

"(1) IN GENERAL.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with such organization the areas of noncompliance or unsatisfactory performance and modify such contract or grant to prevent future occurrences of such noncompliance or unsatisfactory performance.

"(2) NONRENEWAL.—If the Secretary determines, under an evaluation under this section, that noncompliance or unsatisfactory performance cannot be resolved and prevented in the future, the Secretary shall not renew such contract or grant with

such organization and is authorized to enter into a contract or make a grant under section 503 with another urban Indian organization which is situated in the same urban center as the urban Indian organization whose contract or grant is not renewed under this section.

"(d) DETERMINATION OF RENEWAL.—In determining whether to renew a contract or grant with an urban Indian organization under section 503 which has completed performance of a contract or grant under section 504, the Secretary shall review the records of the urban Indian organization, the reports submitted under section 507, and, in the case of a renewal of a contract or grant under section 503, shall consider the results of the onsite evaluations or accreditation under subsection (b).

"SEC. 506. OTHER CONTRACT AND GRANT REQUIREMENTS.

"(a) APPLICATION OF FEDERAL LAW.—Contracts with urban Indian organizations entered into pursuant to this title shall be in accordance with all Federal contracting laws and regulations relating to procurement except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform to the provisions of the Act of August 24, 1935 (40 U.S.C. 270a, et seq.).

"(b) PAYMENTS.—Payments under any contracts or grants pursuant to this title shall, notwithstanding any term or condition of such contract or grant—

"(1) be made in their entirety by the Secretary to the urban Indian organization by not later than the end of the first 30 days of the funding period with respect to which the payments apply, unless the Secretary determines through an evaluation under section 505 that the organization is not capable of administering such payments in their entirety; and

"(2) if unexpended by the urban Indian organization during the funding period with respect to which the payments initially apply, be carried forward for expenditure with respect to allowable or reimbursable costs incurred by the organization during 1 or more subsequent funding periods without additional justification or documentation by the organization as a condition of carrying forward the expenditure of such funds.

"(c) REVISING OR AMENDING CONTRACT.—Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract entered into by the Secretary with such organization under this title as necessary to carry out the purposes of this title.

"(d) FAIR AND UNIFORM PROVISION OF SERVICES.—Contracts with, or grants to, urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants by such organizations.

"(e) ELIGIBILITY OF URBAN INDIANS.—Urban Indians, as defined in section 4(f), shall be eligible for health care or referral services provided pursuant to this title.

"SEC. 507. REPORTS AND RECORDS.

"(a) REPORT.—For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract entered into, or a grant received, pursuant to this title, such organization shall submit to the Secretary, on a basis no more frequent than every 6 months, a report including—

"(1) in the case of a contract or grant under section 503, information gathered pursuant to paragraph (5) of subsection (a) of such section;

"(2) information on activities conducted by the organization pursuant to the contract or grant;

"(3) an accounting of the amounts and purposes for which Federal funds were expended; and

"(4) a minimum set of data, using uniformly defined elements, that is specified by the Secretary,

after consultations consistent with section 514, with urban Indian organizations.

"(b) AUDITS.—The reports and records of the urban Indian organization with respect to a contract or grant under this title shall be subject to audit by the Secretary and the Comptroller General of the United States.

"(c) COST OF AUDIT.—The Secretary shall allow as a cost of any contract or grant entered into or awarded under section 502 or 503 the cost of an annual independent financial audit conducted by—

"(1) a certified public accountant; or

"(2) a certified public accounting firm qualified to conduct Federal compliance audits.

"SEC. 508. LIMITATION ON CONTRACT AUTHORITY.

"The authority of the Secretary to enter into contracts or to award grants under this title shall be to the extent, and in an amount, provided for in appropriation Acts.

"SEC. 509. FACILITIES.

"(a) GRANTS.—The Secretary may make grants to contractors or grant recipients under this title for the lease, purchase, renovation, construction, or expansion of facilities, including leased facilities, in order to assist such contractors or grant recipients in complying with applicable licensure or certification requirements.

"(b) LOANS OR LOAN GUARANTEES.—The Secretary, acting through the Service or through the Health Resources and Services Administration, may provide loans to contractors or grant recipients under this title from the Urban Indian Health Care Facilities Revolving Loan Fund (referred to in this section as the 'URLF') described in subsection (c), or guarantees for loans, for the construction, renovation, expansion, or purchase of health care facilities, subject to the following requirements:

"(1) The principal amount of a loan or loan guarantee may cover 100 percent of the costs (other than staffing) relating to the facility, including planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, medical equipment, furnishings, and capital purchase.

"(2) The total amount of the principal of loans and loan guarantees, respectively, outstanding at any one time shall not exceed such limitations as may be specified in appropriations Acts.

"(3) The loan or loan guarantee may have a term of the shorter of the estimated useful life of the facility, or 25 years.

"(4) An urban Indian organization may assign, and the Secretary may accept assignment of, the

revenue of the organization as security for a loan or loan guarantee under this subsection.

"(5) The Secretary shall not collect application, processing, or similar fees from urban Indian organizations applying for loans or loan guarantees under this subsection.

"(c) URBAN INDIAN HEALTH CARE FACILITIES REVOLVING LOAN FUND.—

"(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Urban Indian Health Care Facilities Revolving Loan Fund. The URLF shall consist of—

"(A) such amounts as may be appropriated to the URLF;

"(B) amounts received from urban Indian organizations in repayment of loans made to such organizations under paragraph (2); and

"(C) interest earned on amounts in the URLF under paragraph (3).

"(2) USE OF URLF.—Amounts in the URLF may be expended by the Secretary, acting through the Service or the Health Resources and Services Administration, to make loans available to urban Indian organizations receiving grants or contracts under this title for the purposes, and subject to the

requirements, described in subsection (b). Amounts appropriated to the URLF, amounts received from urban Indian organizations in repayment of loans, and interest on amounts in the URLF shall remain available until expended.

"(3) INVESTMENTS.—The Secretary of the Treasury shall invest such amounts of the URLF as such Secretary determines are not required to meet current withdrawals from the URLF. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. Any obligation acquired by the URLF may be sold by the Secretary of the Treasury at the market price.

"SEC. 510. OFFICE OF URBAN INDIAN HEALTH.

"There is hereby established within the Service an Office of Urban Indian Health which shall be responsible for—

"(1) carrying out the provisions of this title;

"(2) providing central oversight of the programs and services authorized under this title; and

"(3) providing technical assistance to urban Indian organizations.

"SEC. 511. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE RELATED SERVICES.

"(a) GRANTS.—The Secretary may make grants for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school and community-based education in, alcohol and substance abuse in urban centers to those urban Indian organizations with whom the Secretary has entered into a contract under this title or under section 201.

"(b) GOALS OF GRANT.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

"(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the—

"(1) size of the urban Indian population;

"(2) capability of the organization to adequately perform the activities required under the grant;

"(3) satisfactory performance standards for the organization in meeting the goals set forth in such grant, which standards shall be negotiated and agreed to between the Secretary and the grantee on a grant-by-grant basis; and

"(4) identification of need for services.

The Secretary shall develop a methodology for allocating grants made pursuant to this section based on such criteria.

"(d) TREATMENT OF FUNDS RECEIVED BY URBAN INDIAN ORGANIZATIONS.—Any funds received by an urban Indian organization under this Act for substance abuse prevention, treatment, and rehabilitation shall be subject to the criteria set forth in subsection (c).

"SEC. 512. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

"(a) OKLAHOMA CITY CLINIC.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Oklahoma City Clinic demonstration project shall be treated as a service unit in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance Act for the term of such projects. The Secretary shall provide assistance to such projects in the development of resources and equipment and facility needs.

"(2) REPORT.—The Secretary shall submit to the President, for inclusion in the report required to be submitted to the Congress under section 801 for fiscal year 1999, a report on the findings and con-

clusions derived from the demonstration project specified in paragraph (1).

"(b) TULSA CLINIC.—Notwithstanding any other provision of law, the Tulsa Clinic demonstration project shall become a permanent program within the Service's direct care program and continue to be treated as a service unit in the allocation of resources and coordination of care, and shall continue to meet the requirements and definitions of an urban Indian organization in this title, and as such will not be subject to the provisions of the Indian Self-Determination and Education Assistance Act.

"SEC. 513. URBAN NIAAA TRANSFERRED PROGRAMS.

"(a) GRANTS AND CONTRACTS.—The Secretary, acting through the Office of Urban Indian Health of the Service, shall make grants or enter into contracts, effective not later than September 30, 2001, with urban Indian organizations for the administration of urban Indian alcohol programs that were originally established under the National Institute on Alcoholism and Alcohol Abuse (referred to in this section to as 'NIAAA') and transferred to the Service.

"(b) USE OF FUNDS.—Grants provided or contracts entered into under this section shall be used to provide support for the continuation of alcohol prevention and treatment services for urban Indian populations and such

other objectives as are agreed upon between the Service and a recipient of a grant or contract under this section.

"(c) ELIGIBILITY.—Urban Indian organizations that operate Indian alcohol programs originally funded under NIAAA and subsequently transferred to the Service are eligible for grants or contracts under this section.

"(d) EVALUATION AND REPORT.—The Secretary shall evaluate and report to the Congress on the activities of programs funded under this section at least every 5 years.

"SEC. 514. CONSULTATION WITH URBAN INDIAN ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary shall ensure that the Service, the Health Care Financing Administration, and other operating divisions and staff divisions of the Department consult, to the maximum extent practicable, with urban Indian organizations (as defined in section 4) prior to taking any action, or approving Federal financial assistance for any action of a State, that may affect urban Indians or urban Indian organizations.

"(b) REQUIREMENT.—In subsection (a), the term 'consultation' means the open and free exchange of information and opinion among urban Indian organizations and the operating and staff divisions of the Department which leads to mutual understanding and comprehension

and which emphasizes trust, respect, and shared responsibility.

"SEC. 515. FEDERAL TORT CLAIMS ACT COVERAGE.

"For purposes of section 224 of the Public Health Service Act (42 U.S.C. 233), with respect to claims by any person, initially filed on or after October 1, 1999, whether or not such person is an Indian or Alaska Native or is served on a fee basis or under other circumstances as permitted by Federal law or regulations, for personal injury (including death) resulting from the performance prior to, including, or after October 1, 1999, of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations, or for purposes of section 2679 of title 28, United States Code, with respect to claims by any such person, on or after October 1, 1999, for personal injury (including death) resulting from the operation of an emergency motor vehicle, an urban Indian organization that has entered into a contract or received a grant pursuant to this title is deemed to be part of the Public Health Service while carrying out any such contract or grant and its employees (including those acting on behalf of the organization as provided for in section 2671 of title 28, United States Code, and including an individual who provides health care services pursuant to a personal services contract with an urban Indian orga-

nization for the provision of services in any facility owned, operated, or constructed under the jurisdiction of the Indian Health Service) are deemed employees of the Service while acting within the scope of their employment in carrying out the contract or grant, except that such employees shall be deemed to be acting within the scope of their employment in carrying out the contract or grant when they are required, by reason of their employment, to perform medical, surgical, dental or related functions at a facility other than a facility operated by the urban Indian organization pursuant to such contract or grant, but only if such employees are not compensated for the performance of such functions by a person or entity other than the urban Indian organization.

"SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

"(a) CONSTRUCTION AND OPERATION.—The Secretary, acting through the Service, shall, through grants or contracts, make payment for the construction and operation of at least 2 residential treatment centers in each State described in subsection (b) to demonstrate the provision of alcohol and substance abuse treatment services to urban Indian youth in a culturally competent residential setting.

"(b) STATES.—A State described in this subsection is a State in which—

"(1) there reside urban Indian youth with a need for alcohol and substance abuse treatment services in a residential setting; and

"(2) there is a significant shortage of culturally competent residential treatment services for urban Indian youth.

"SEC. 517. USE OF FEDERAL GOVERNMENT FACILITIES AND SOURCES OF SUPPLY.

"(a) IN GENERAL.—The Secretary shall permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title, in carrying out such contract or grant, to use existing facilities and all equipment therein or pertaining thereto and other personal property owned by the Federal Government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

"(b) DONATION OF PROPERTY.—Subject to subsection (d), the Secretary may donate to an urban Indian organization that has entered into a contract or received a grant pursuant to this title any personal or real property determined to be excess to the needs of the Service or the

General Services Administration for purposes of carrying out the contract or grant.

"(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

"(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsections (b) or (c) from an urban Indian organization and from an Indian tribe or tribal organization, the Secretary shall give priority to the request for donation to the Indian tribe or tribal organization if the Secretary receives the request from the Indian tribe or tribal organization before the date on which the Secretary transfers title to the property or, if earlier, the date on which the Secretary transfers the property physically, to the urban Indian organization.

"(e) RELATION TO FEDERAL SOURCES OF SUPPLY.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply, in-

cluding lodging providers, airlines, and other transportation providers), an urban Indian organization that has entered into a contract or received a grant pursuant to this title shall be deemed an executive agency when carrying out such contract or grant, and the employees of the urban Indian organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access.

"SEC. 518. GRANTS FOR DIABETES PREVENTION, TREATMENT AND CONTROL.

"(a) AUTHORITY.—The Secretary may make grants to those urban Indian organizations that have entered into a contract or have received a grant under this title for the provision of services for the prevention, treatment, and control of the complications resulting from, diabetes among urban Indians.

"(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished under the grant. The goals shall be specific to each grant as agreed upon between the Secretary and the grantee.

"(c) CRITERIA.—The Secretary shall establish criteria for the awarding of grants made under subsection (a) relating to—

"(1) the size and location of the urban Indian population to be served;

"(2) the need for the prevention of, treatment of, and control of the complications resulting from diabetes among the urban Indian population to be served;

"(3) performance standards for the urban Indian organization in meeting the goals set forth in such grant that are negotiated and agreed to by the Secretary and the grantee;

"(4) the capability of the urban Indian organization to adequately perform the activities required under the grant; and

"(5) the willingness of the urban Indian organization to collaborate with the registry, if any, established by the Secretary under section 204(e) in the area office of the Service in which the organization is located.

"(d) APPLICATION OF CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

"SEC. 519. COMMUNITY HEALTH REPRESENTATIVES.

"The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the use of Indians trained as health

service providers through the Community Health Representatives Program under section 107(b) in the provision of health care, health promotion, and disease prevention services to urban Indians.

"SEC. 520. REGULATIONS.

"(a) EFFECT OF TITLE.—This title shall be effective on the date of enactment of this Act regardless of whether the Secretary has promulgated regulations implementing this title.

"(b) PROMULGATION.—

"(1) IN GENERAL.—The Secretary may promulgate regulations to implement the provisions of this title.

"(2) PUBLICATION.—Proposed regulations to implement this title shall be published by the Secretary in the Federal Register not later than 270 days after the date of enactment of this Act and shall have a comment period of not less than 120 days.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this title shall expire on the date that is 18 months after the date of enactment of this Act.

"(c) NEGOTIATED RULEMAKING COMMITTEE.—A negotiated rulemaking committee shall be established pursu-

ant to section 565 of title 5, United States Code, to carry out this section and shall, in addition to Federal representatives, have as the majority of its members representatives of urban Indian organizations from each service area.

"(d) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of this Act.

"SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VI—ORGANIZATIONAL IMPROVEMENTS

"SEC. 601. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department the Indian Health Service.

"(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistance Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

"(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

"(c) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

"(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the direction of the individual serving as Director of the Service on such day;

"(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for,

and provision and utilization of, health services for Indians;

"(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

"(A) this Act;

"(B) the Act of November 2, 1921 (25 U.S.C. 13);

"(C) the Act of August 5, 1954 (42 U.S.C. 2001, et seq.);

"(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

"(E) the Indian Self-Determination Act (25 U.S.C. 450f, et seq.); and

"(4) all scholarship and loan functions carried out under title I.

"(d) AUTHORITY.—

"(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the authority—

"(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

"(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

"(C) to manage, expend, and obligate all funds appropriated for the Service.

"(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

"SEC. 602. AUTOMATED MANAGEMENT INFORMATION SYSTEM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, in consultation with tribes, tribal organizations, and urban Indian organizations, shall establish an automated management information system for the Service.

"(2) REQUIREMENTS OF SYSTEM.—The information system established under paragraph (1) shall include—

"(A) a financial management system;

"(B) a patient care information system;

"(C) a privacy component that protects the privacy of patient information;

"(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each area office of the Service;

"(E) an interface mechanism for patient billing and accounts receivable system; and

"(F) a training component.

"(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Indian tribe and tribal organization that provides health services under a contract entered into with the Service under the Indian Self-Determination Act automated management information systems which—

"(1) meet the management information needs of such Indian tribe or tribal organization with respect to the treatment by the Indian tribe or tribal organization of patients of the Service; and

"(2) meet the management information needs of the Service.

"(c) ACCESS TO RECORDS.—Notwithstanding any other provision of law, each patient shall have reasonable

access to the medical or health records of such patient which are held by, or on behalf of, the Service.

"(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities.

"SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

"(a) PURPOSES.—It is the purpose of this section to—

"(1) authorize and direct the Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations to develop a comprehensive behavioral health prevention and treatment program which emphasizes collaboration

among alcohol and substance abuse, social services, and mental health programs;

"(2) provide information, direction and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Federal, tribal, State and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement and judicial services;

"(3) assist Indian tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior;

"(4) provide authority and opportunities for Indian tribes to develop and implement, and coordinate with, community-based programs which include identification, prevention, education, referral, and treatment services, including through multi-disciplinary resource teams;

"(5) ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access; and

"(6) modify or supplement existing programs and authorities in the areas identified in paragraph (2).

"(b) BEHAVIORAL HEALTH PLANNING.—

"(1) AREA-WIDE PLANS.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations, shall encourage Indian tribes and tribal organizations to develop tribal plans, encourage urban Indian organizations to develop local plans, and encourage all such groups to participate in developing area-wide plans for Indian Behavioral Health Services. The plans shall, to the extent feasible, include—

"(A) an assessment of the scope of the problem of alcohol or other substance abuse, mental illness, dysfunctional and self-destructive behavior, including suicide, child abuse and family violence, among Indians, including—

"(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; and

"(ii) an estimate of the financial and human cost attributable to such illness or behavior;

"(B) an assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including an assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c); and

"(C) an estimate of the additional funding needed by the Service, Indian tribes, tribal organizations and urban Indian organizations to meet their responsibilities under the plans.

"(2) NATIONAL CLEARINGHOUSE.—The Secretary shall establish a national clearinghouse of plans and reports on the outcomes of such plans developed under this section by Indian tribes, tribal organizations and by areas relating to behavioral health. The Secretary shall ensure access to such plans and outcomes by any Indian tribe, tribal organization, urban Indian organization or the Service.

"(3) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian tribes, tribal organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be utilized and adopted locally.

"(c) CONTINUUM OF CARE.—The Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, to the extent feasible and to the extent that funding is available, for the implementation of programs including—

"(1) a comprehensive continuum of behavioral health care that provides for—

"(A) community based prevention, intervention, outpatient and behavioral health aftercare;

"(B) detoxification (social and medical);

"(C) acute hospitalization;

"(D) intensive outpatient or day treatment;

"(E) residential treatment;

"(F) transitional living for those needing a temporary stable living environment that is supportive of treatment or recovery goals;

"(G) emergency shelter;

"(H) intensive case management; and

"(I) traditional health care practices; and

"(2) behavioral health services for particular populations, including—

"(A) for persons from birth through age 17, child behavioral health services, that include—

"(i) pre-school and school age fetal alcohol disorder services, including assessment and behavioral intervention);

"(ii) mental health or substance abuse services (emotional, organic, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (multiple diagnosis);

"(iv) prevention services that are focused on individuals ages 5 years through 10 years (alcohol, drug, inhalant and tobacco);

"(v) early intervention, treatment and aftercare services that are focused on individuals ages 11 years through 17 years;

"(vi) healthy choices or life style services (related to STD's, domestic violence, sexual abuse, suicide, teen pregnancy, obesity, and other risk or safety issues);

"(vii) co-morbidity services;

"(B) for persons ages 18 years through 55 years, adult behavioral health services that include—

"(i) early intervention, treatment and aftercare services;

"(ii) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(iii) services for co-occurring disorders (dual diagnosis) and co-morbidity;

"(iv) healthy choices and life style services (related to parenting, partners, domestic violence, sexual abuse, suicide, obesity, and other risk related behavior);

"(v) female specific treatment services for—

"(I) women at risk of giving birth to a child with a fetal alcohol disorder;

"(II) substance abuse requiring gender specific services;

"(III) sexual assault and domestic violence; and

"(IV) healthy choices and life style (parenting, partners, obesity,

suicide and other related behavioral risk); and

"(vi) male specific treatment services for—

"(I) substance abuse requiring gender specific services;

"(II) sexual assault and domestic violence; and

"(III) healthy choices and life style (parenting, partners, obesity, suicide and other risk related behavior);

"(C) family behavioral health services, including—

"(i) early intervention, treatment and aftercare for affected families;

"(ii) treatment for sexual assault and domestic violence; and

"(iii) healthy choices and life style (related to parenting, partners, domestic violence and other abuse issues);

"(D) for persons age 56 years and older, elder behavioral health services including—

"(i) early intervention, treatment and aftercare services that include—

"(I) mental health and substance abuse services (emotional, alcohol, drug, inhalant and tobacco);

"(II) services for co-occurring disorders (dual diagnosis) and co-morbidity; and

"(III) healthy choices and life style services (managing conditions related to aging);

"(ii) elder women specific services that include—

"(I) treatment for substance abuse requiring gender specific services and

"(II) treatment for sexual assault, domestic violence and neglect;

"(iii) elder men specific services that include—

"(I) treatment for substance abuse requiring gender specific services; and

"(II) treatment for sexual assault, domestic violence and neglect; and

"(iv) services for dementia regardless of cause.

"(d) COMMUNITY BEHAVIORAL HEALTH PLAN.—

"(1) IN GENERAL.—The governing body of any Indian tribe or tribal organization or urban Indian organization may, at its discretion, adopt a resolution for the establishment of a community behavioral health plan providing for the identification and coordination of available resources and programs to identify, prevent, or treat alcohol and other substance abuse, mental illness or dysfunctional and self-destructive behavior, including child abuse and family violence, among its members or its service population. Such plan should include behavioral health services, social services, intensive outpatient services, and continuing after care.

"(2) TECHNICAL ASSISTANCE.—In furtherance of a plan established pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the Indian tribe or tribal organization in the development of a plan under paragraph (1). Upon the establishment of such a plan and at the request of the Indian tribe

or tribal organization, such officials shall cooperate with the Indian tribe or tribal organization in the implementation of such plan.

"(3) FUNDING.—The Secretary, acting through the Service, may make funding available to Indian tribes and tribal organizations adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

"(e) COORDINATED PLANNING.—The Secretary, acting through the Service, Indian tribes, tribal organizations, and urban Indian organizations shall coordinate behavioral health planning, to the extent feasible, with other Federal and State agencies, to ensure that comprehensive behavioral health services are available to Indians without regard to their place of residence.

"(f) FACILITIES ASSESSMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indians and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary shall consider the possible conver-

sion of existing, under-utilized service hospital beds into psychiatric units to meet such need.

"SEC. 702. MEMORANDUM OF AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Secretary of the Interior shall develop and enter into a memorandum of agreement, or review and update any existing memoranda of agreement as required under section 4205 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2411), and under which the Secretaries address—

"(1) the scope and nature of mental illness and dysfunctional and self-destructive behavior, including child abuse and family violence, among Indians;

"(2) the existing Federal, tribal, State, local, and private services, resources, and programs available to provide mental health services for Indians;

"(3) the unmet need for additional services, resources, and programs necessary to meet the needs identified pursuant to paragraph (1);

"(4)(A) the right of Indians, as citizens of the United States and of the States in which they reside, to have access to mental health services to which all citizens have access;

"(B) the right of Indians to participate in, and receive the benefit of, such services; and

"(C) the actions necessary to protect the exercise of such right;

"(5) the responsibilities of the Bureau of Indian Affairs and the Service, including mental health identification, prevention, education, referral, and treatment services (including services through multidisciplinary resource teams), at the central, area, and agency and service unit levels to address the problems identified in paragraph (1);

"(6) a strategy for the comprehensive coordination of the mental health services provided by the Bureau of Indian Affairs and the Service to meet the needs identified pursuant to paragraph (1), including—

"(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various Indian tribes (developed under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986) with the mental health initiatives pursuant to this Act, particularly with respect to the referral and treatment of dually-diag-

nosed individuals requiring mental health and substance abuse treatment; and

"(B) ensuring that Bureau of Indian Affairs and Service programs and services (including multidisciplinary resource teams) addressing child abuse and family violence are coordinated with such non-Federal programs and services;

"(7) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to community behavioral health plans adopted under section 701(c) and section 4206 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2412); and

"(8) provide for an annual review of such agreement by the 2 Secretaries and a report which shall be submitted to Congress and made available to the Indian tribes.

"(b) SPECIFIC PROVISIONS.—The memorandum of agreement updated or entered into pursuant to subsection (a) shall include specific provisions pursuant to which the Service shall assume responsibility for—

"(1) the determination of the scope of the problem of alcohol and substance abuse among Indian people, including the number of Indians within the jurisdiction of the Service who are directly or indirectly affected by alcohol and substance abuse and the financial and human cost;

"(2) an assessment of the existing and needed resources necessary for the prevention of alcohol and substance abuse and the treatment of Indians affected by alcohol and substance abuse; and

"(3) an estimate of the funding necessary to adequately support a program of prevention of alcohol and substance abuse and treatment of Indians affected by alcohol and substance abuse.

"(c) CONSULTATION.—The Secretary and the Secretary of the Interior shall, in developing the memorandum of agreement under subsection (a), consult with and solicit the comments of—

"(1) Indian tribes and tribal organizations;

"(2) Indian individuals;

"(3) urban Indian organizations and other Indian organizations;

"(4) behavioral health service providers.

"(d) PUBLICATION.—The memorandum of agreement under subsection (a) shall be published in the Fed-

eral Register. At the same time as the publication of such agreement in the Federal Register, the Secretary shall provide a copy of such memorandum to each Indian tribe, tribal organization, and urban Indian organization.

"SEC. 703. COMPREHENSIVE BEHAVIORAL HEALTH PREVENTION AND TREATMENT PROGRAM.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—The Secretary, acting through the Service, Indian tribes and tribal organizations consistent with section 701, shall provide a program of comprehensive behavioral health prevention and treatment and aftercare, including traditional health care practices, which shall include—

"(A) prevention, through educational intervention, in Indian communities;

"(B) acute detoxification or psychiatric hospitalization and treatment (residential and intensive outpatient);

"(C) community-based rehabilitation and aftercare;

"(D) community education and involvement, including extensive training of health care, educational, and community-based personnel; and

"(E) specialized residential treatment programs for high risk populations including pregnant and post partum women and their children.

"(2) TARGET POPULATIONS.—The target population of the program under paragraph (1) shall be members of Indian tribes. Efforts to train and educate key members of the Indian community shall target employees of health, education, judicial, law enforcement, legal, and social service programs.

"(b) CONTRACT HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service (with the consent of the Indian tribe to be served), Indian tribes and tribal organizations, may enter into contracts with public or private providers of behavioral health treatment services for the purpose of carrying out the program required under subsection (a).

"(2) PROVISION OF ASSISTANCE.—In carrying out this subsection, the Secretary shall provide assistance to Indian tribes and tribal organizations to develop criteria for the certification of behavioral health service providers and accreditation of service facilities which meet minimum standards for such services and facilities.

"SEC. 704. MENTAL HEALTH TECHNICIAN PROGRAM.

"(a) IN GENERAL.—Under the authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act), the Secretary shall establish and maintain a Mental Health Technician program within the Service which—

"(1) provides for the training of Indians as mental health technicians; and

"(2) employs such technicians in the provision of community-based mental health care that includes identification, prevention, education, referral, and treatment services.

"(b) TRAINING.—In carrying out subsection (a)(1), the Secretary shall provide high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

"(c) SUPERVISION AND EVALUATION.—The Secretary shall supervise and evaluate the mental health technicians in the training program under this section.

"(d) TRADITIONAL CARE.—The Secretary shall ensure that the program established pursuant to this section involves the utilization and promotion of the traditional

Indian health care and treatment practices of the Indian tribes to be served.–

"SEC. 705. LICENSING REQUIREMENT FOR MENTAL HEALTH CARE WORKERS.

"Subject to section 220, any person employed as a psychologist, social worker, or marriage and family therapist for the purpose of providing mental health care services to Indians in a clinical setting under the authority of this Act or through a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act shall—

"(1) in the case of a person employed as a psychologist to provide health care services, be licensed as a clinical or counseling psychologist, or working under the direct supervision of a clinical or counseling psychologist;

"(2) in the case of a person employed as a social worker, be licensed as a social worker or working under the direct supervision of a licensed social worker; or

"(3) in the case of a person employed as a marriage and family therapist, be licensed as a marriage and family therapist or working under the direct supervision of a licensed marriage and family therapist.

"SEC. 706. INDIAN WOMEN TREATMENT PROGRAMS.

"(a) FUNDING.—The Secretary, consistent with section 701, shall make funding available to Indian tribes, tribal organizations and urban Indian organization to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and relapse prevention services that specifically addresses the spiritual, cultural, historical, social, and child care needs of Indian women, regardless of age.

"(b) USE OF FUNDS.—Funding provided pursuant to this section may be used to—

"(1) develop and provide community training, education, and prevention programs for Indian women relating to behavioral health issues, including fetal alcohol disorders;

"(2) identify and provide psychological services, counseling, advocacy, support, and relapse prevention to Indian women and their families; and

"(3) develop prevention and intervention models for Indian women which incorporate traditional health care practices, cultural values, and community and family involvement.

"(c) CRITERIA.—The Secretary, in consultation with Indian tribes and tribal organizations, shall establish criteria for the review and approval of applications and proposals for funding under this section.

"(d) EARMARK OF CERTAIN FUNDS.—Twenty percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 707. INDIAN YOUTH PROGRAM.

"(a) DETOXIFICATION AND REHABILITATION.—The Secretary shall, consistent with section 701, develop and implement a program for acute detoxification and treatment for Indian youth that includes behavioral health services. The program shall include regional treatment centers designed to include detoxification and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian tribes or tribal organizations at the local level under the Indian Self-Determination and Education Assistance Act. Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

"(b) ALCOHOL AND SUBSTANCE ABUSE TREATMENT CENTERS OR FACILITIES.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—The Secretary, acting through the Service, Indian tribes, or tribal organizations, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth regional treatment

center or treatment network in each area under the jurisdiction of an area office.

"(B) AREA OFFICE IN CALIFORNIA.—For purposes of this subsection, the area office in California shall be considered to be 2 area offices, 1 office whose jurisdiction shall be considered to encompass the northern area of the State of California, and 1 office whose jurisdiction shall be considered to encompass the remainder of the State of California for the purpose of implementing California treatment networks.

"(2) FUNDING.—For the purpose of staffing and operating centers or facilities under this subsection, funding shall be made available pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the Snyder Act).

"(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (1) that is agreed upon (by appropriate tribal resolution) by a majority of the tribes to be served by such center.

"(4) SPECIFIC PROVISION OF FUNDS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated for the purposes of carrying out this section, make funds available to—

"(i) the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, constructing, renovating, operating and maintaining a residential youth treatment facility in Fairbanks, Alaska;

"(ii) the Southeast Alaska Regional Health Corporation to staff and operate a residential youth treatment facility without regard to the proviso set forth in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(l));

"(iii) the Southern Indian Health Council, for the purpose of staffing, operating, and maintaining a residential youth treatment facility in San Diego County, California; and

"(iv) the Navajo Nation, for the staffing, operation, and maintenance of the Four Corners Regional Adolescent Treat-

ment Center, a residential youth treatment facility in New Mexico.

"(B) PROVISION OF SERVICES TO ELIGIBLE YOUTH.—Until additional residential youth treatment facilities are established in Alaska pursuant to this section, the facilities specified in subparagraph (A) shall make every effort to provide services to all eligible Indian youth residing in such State.

"(c) INTERMEDIATE ADOLESCENT BEHAVIORAL HEALTH SERVICES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, Indian Tribes and tribal organizations, may provide intermediate behavioral health services, which may incorporate traditional health care practices, to Indian children and adolescents, including—

"(A) pre-treatment assistance;

"(B) inpatient, outpatient, and after-care services;

"(C) emergency care;

"(D) suicide prevention and crisis intervention; and

"(E) prevention and treatment of mental illness, and dysfunctional and –self-destructive

behavior, including child abuse and family violence.

"(2) USE OF FUNDS.—Funds provided under this subsection may be used—

"(A) to construct or renovate an existing health facility to provide intermediate behavioral health services;

"(B) to hire behavioral health professionals;

"(C) to staff, operate, and maintain an intermediate mental health facility, group home, sober housing, transitional housing or similar facilities, or youth shelter where intermediate behavioral health services are being provided; and

"(D) to make renovations and hire appropriate staff to convert existing hospital beds into adolescent psychiatric units; and

"(E) intensive home and community based services.

"(3) CRITERIA.—The Secretary shall, in consultation with Indian tribes and tribal organizations, establish criteria for the review and approval of applications or proposals for funding made available pursuant to this subsection.

"(d) FEDERALLY OWNED STRUCTURES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, shall, in consultation with Indian tribes and tribal organizations—

"(A) identify and use, where appropriate, federally owned structures suitable for local residential or regional behavioral health treatment for Indian youth; and

"(B) establish guidelines, in consultation with Indian tribes and tribal organizations, for determining the suitability of any such Federally owned structure to be used for local residential or regional behavioral health treatment for Indian youth.

"(2) TERMS AND CONDITIONS FOR USE OF STRUCTURE.—Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary and the agency having responsibility for the structure and any Indian tribe or tribal organization operating the program.

"(e) REHABILITATION AND AFTERCARE SERVICES.—

"(1) IN GENERAL.—The Secretary, an Indian tribe or tribal organization, in cooperation with the Secretary of the Interior, shall develop and imple-

ment within each service unit, community-based rehabilitation and follow-up services for Indian youth who have significant behavioral health problems, and require long-term treatment, community reintegration, and monitoring to support the Indian youth after their return to their home community.

"(2) ADMINISTRATION.—Services under paragraph (1) shall be administered within each service unit or tribal program by trained staff within the community who can assist the Indian youth in continuing development of self-image, positive problem-solving skills, and nonalcohol or substance abusing behaviors. Such staff may include alcohol and substance abuse counselors, mental health professionals, and other health professionals and paraprofessionals, including community health representatives.

"(f) INCLUSION OF FAMILY IN YOUTH TREATMENT PROGRAM.—In providing the treatment and other services to Indian youth authorized by this section, the Secretary, an Indian tribe or tribal organization shall provide for the inclusion of family members of such youth in the treatment programs or other services as may be appropriate. Not less than 10 percent of the funds appropriated for the purposes of carrying out subsection (e) shall be used

for outpatient care of adult family members related to the treatment of an Indian youth under that subsection.

"(g) MULTIDRUG ABUSE PROGRAM.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall provide, consistent with section 701, programs and services to prevent and treat the abuse of multiple forms of substances, including alcohol, drugs, inhalants, and tobacco, among Indian youth residing in Indian communities, on Indian reservations, and in urban areas and provide appropriate mental health services to address the incidence of mental illness among such youth.

"SEC. 708. INPATIENT AND COMMUNITY-BASED MENTAL HEALTH FACILITIES DESIGN, CONSTRUCTION AND STAFFING ASSESSMENT.—

"(a) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Secretary, acting through the Service, Indian tribes and tribal organizations, shall provide, in each area of the Service, not less than 1 inpatient mental health care facility, or the equivalent, for Indians with behavioral health problems.

"(b) TREATMENT OF CALIFORNIA.—For purposes of this section, California shall be considered to be 2 areas of the Service, 1 area whose location shall be considered to encompass the northern area of the State of California

and 1 area whose jurisdiction shall be considered to encompass the remainder of the State of California.

"(c) CONVERSION OF CERTAIN HOSPITAL BEDS.—The Secretary shall consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet needs under this section.–

"SEC. 709. TRAINING AND COMMUNITY EDUCATION.

"(a) COMMUNITY EDUCATION.—

"(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of the Interior, shall develop and implement, or provide funding to enable Indian tribes and tribal organization to develop and implement, within each service unit or tribal program a program of community education and involvement which shall be designed to provide concise and timely information to the community leadership of each tribal community.

"(2) EDUCATION.—A program under paragraph (1) shall include education concerning behavioral health for political leaders, tribal judges, law enforcement personnel, members of tribal health and education boards, and other critical members of each tribal community.

"(3) TRAINING.—Community-based training (oriented toward local capacity development) under a

program under paragraph (1) shall include tribal community provider training (designed for adult learners from the communities receiving services for prevention, intervention, treatment and aftercare).

"(b) TRAINING.—The Secretary shall, either directly or through Indian tribes or tribal organization, provide instruction in the area of behavioral health issues, including instruction in crisis intervention and family relations in the context of alcohol and substance abuse, child sexual abuse, youth alcohol and substance abuse, and the causes and effects of fetal alcohol disorders, to appropriate employees of the Bureau of Indian Affairs and the Service, and to personnel in schools or programs operated under any contract with the Bureau of Indian Affairs or the Service, including supervisors of emergency shelters and halfway houses described in section 4213 of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2433).

"(c) COMMUNITY-BASED TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, acting through the Service and in consultation with Indian tribes, tribal organizations, Indian behavioral health experts, and Indian alcohol and substance abuse prevention experts, shall develop and

provide community-based training models. Such models shall address—

"(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

"(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

"(3) community-based and multidisciplinary strategies for preventing and treating behavioral health problems.

"SEC. 710. BEHAVIORAL HEALTH PROGRAM.

"(a) PROGRAMS FOR INNOVATIVE SERVICES.—The Secretary, acting through the Service, Indian Tribes or tribal organizations, consistent with Section 701, may develop, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

"(b) CRITERIA.—The Secretary may award funding for a project under subsection (a) to an Indian tribe or tribal organization and may consider the following criteria:

"(1) Whether the project will address significant unmet behavioral health needs among Indians.

"(2) Whether the project will serve a significant number of Indians.

"(3) Whether the project has the potential to deliver services in an efficient and effective manner.

"(4) Whether the tribe or tribal organization has the administrative and financial capability to administer the project.

"(5) Whether the project will deliver services in a manner consistent with traditional health care.

"(6) Whether the project is coordinated with, and avoids duplication of, existing services.

"(c) FUNDING AGREEMENTS.—For purposes of this subsection, the Secretary shall, in evaluating applications or proposals for funding for projects to be operated under any funding agreement entered into with the Service under the Indian Self-Determination Act and Education Assistance Act, use the same criteria that the Secretary uses in evaluating any other application or proposal for such funding.

"SEC. 711. FETAL ALCOHOL DISORDER FUNDING.

"(a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—The Secretary, consistent with Section 701, acting through Indian tribes, tribal organizations, and urban Indian organizations, shall establish and operate fetal alcohol disorders programs as provided for in this section for the pur-

poses of meeting the health status objective specified in section 3(b).

"(2) USE OF FUNDS.—Funding provided pursuant to this section shall be used to—

"(A) develop and provide community and in-school training, education, and prevention programs relating to fetal alcohol disorders;

"(B) identify and provide behavioral health treatment to high-risk women;

"(C) identify and provide appropriate educational and vocational support, counseling, advocacy, and information to fetal alcohol disorder affected persons and their families or caretakers;

"(D) develop and implement counseling and support programs in schools for fetal alcohol disorder affected children;

"(E) develop prevention and intervention models which incorporate traditional practitioners, cultural and spiritual values and community involvement;

"(F) develop, print, and disseminate education and prevention materials on fetal alcohol disorders;

"(G) develop and implement, through the tribal consultation process, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in tribal and urban Indian communities;

"(H) develop early childhood intervention projects from birth on to mitigate the effects of fetal alcohol disorders; and

"(I) develop and fund community-based adult fetal alcohol disorder housing and support services.

"(3) CRITERIA.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

"(b) PROVISION OF SERVICES.—The Secretary, acting through the Service, Indian tribes, tribal organizations and urban Indian organizations, shall—

"(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorders in Indian communities; and

"(2) provide supportive services, directly or through an Indian tribe, tribal organization or urban Indian organization, including services to meet the

special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorders.

"(c) TASK FORCE.—

"(1) IN GENERAL.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorders Task Force to advise the Secretary in carrying out subsection (b).

"(2) COMPOSITION.—The task force under paragraph (1) shall be composed of representatives from the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism, the Office of Substance Abuse Prevention, the National Institute of Mental Health, the Service, the Office of Minority Health of the Department of Health and Human Services, the Administration for Native Americans, the National Institute of Child Health & Human Development, the Centers for Disease Control and Prevention, the Bureau of Indian Affairs, Indian tribes, tribal organizations, urban Indian communities, and Indian fetal alcohol disorders experts.

"(d) APPLIED RESEARCH.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make funding available to Indian

Tribes, tribal organizations and urban Indian organizations for applied research projects which propose to elevate the understanding of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol disorders.

"(e) URBAN INDIAN ORGANIZATIONS.—The Secretary shall ensure that 10 percent of the amounts appropriated to carry out this section shall be used to make grants to urban Indian organizations funded under title V.

"SEC. 712. CHILD SEXUAL ABUSE AND PREVENTION TREATMENT PROGRAMS.

"(a) ESTABLISHMENT.—The Secretary and the Secretary of the Interior, acting through the Service, Indian tribes and tribal organizations, shall establish, consistent with section 701, in each service area, programs involving treatment for—

"(1) victims of child sexual abuse; and

"(2) perpetrators of child sexual abuse.

"(b) USE OF FUNDS.—Funds provided under this section shall be used to—

"(1) develop and provide community education and prevention programs related to child sexual abuse;

"(2) identify and provide behavioral health treatment to children who are victims of sexual abuse and to their families who are affected by sexual abuse;

"(3) develop prevention and intervention models which incorporate traditional health care practitioners, cultural and spiritual values, and community involvement;

"(4) develop and implement, though the tribal consultation process, culturally sensitive assessment and diagnostic tools for use in tribal and urban Indian communities.

"(5) identify and provide behavioral health treatment to perpetrators of child sexual abuse with efforts being made to begin offender and behavioral health treatment while the perpetrator is incarcerated or at the earliest possible date if the perpetrator is not incarcerated, and to provide treatment after release to the community until it is determined that the perpetrator is not a threat to children.

"SEC. 713. BEHAVIORAL MENTAL HEALTH RESEARCH.

"(a) IN GENERAL.—The Secretary, acting through the Service and in consultation with appropriate Federal agencies, shall provide funding to Indian Tribes, tribal organizations and urban Indian organizations or, enter into

contracts with, or make grants to appropriate institutions, for the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

"(1) the inter-relationship and inter-dependance of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

"(2) the development of models of prevention techniques.

"(b) SPECIAL EMPHASIS.—The effect of the inter-relationships and interdependencies referred to in subsection (a)(1) on children, and the development of prevention techniques under subsection (a)(2) applicable to children, shall be emphasized.

"SEC. 714. DEFINITIONS.

"In this title:

"(1) ASSESSMENT.—The term 'assessment' means the systematic collection, analysis and dissemination of information on health status, health needs and health problems.

"(2) ALCOHOL RELATED NEURODEVELOP-MENTAL DISORDERS.—The term 'alcohol related

neurodevelop-mental disorders' or 'ARND' with respect to an individual means the individual has a history of maternal alcohol consumption during pregnancy, central nervous system involvement such as developmental delay, intellectual deficit, or neurologic abnormalities, that behaviorally, there may be problems with irritability, and failure to thrive as infants, and that as children become older there will likely be hyperactivity, attention deficit, language dysfunction and perceptual and judgment problems.

"(3) BEHAVIORAL HEALTH.—The term 'behavioral health' means the blending of substances (alcohol, drugs, inhalants and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services. Such term includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

"(4) BEHAVIORAL HEALTH AFTERCARE.—

"(A) IN GENERAL.—The term 'behavioral health aftercare' includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse

or mental health outpatient or outpatient treatment, to help prevent or treat relapse, including the development of an aftercare plan.

"(B) AFTERCARE PLAN.—Prior to the time at which an individual is discharged from a level of care, such as outpatient treatment, an aftercare plan shall have been developed for the individual. Such plan may use such resources as community base therapeutic group care, transitional living, a 12-step sponsor, a local 12-step or other related support group, or other community based providers (such as mental health professionals, traditional health care practitioners, community health aides, community health representatives, mental health technicians, or ministers).

"(5) DUAL DIAGNOSIS.—The term 'dual diagnosis' means coexisting substance abuse and mental illness conditions or diagnosis. In individual with a dual diagnosis may be referred to as a mentally ill chemical abuser.–

"(6) FETAL ALCOHOL DISORDERS.—The term 'fetal alcohol disorders' means fetal alcohol syndrome, partial fetal alcohol syndrome, or alcohol related neural developmental disorder.

"(7) FETAL ALCOHOL SYNDROME.—The term 'fetal alcohol syndrome' or 'FAS' with respect to an individual means a syndrome in which the individual has a history of maternal alcohol consumption during pregnancy, and with respect to which the following criteria should be met:

"(A) Central nervous system involvement such as developmental delay, intellectual deficit, microencephaly, or neurologic abnormalities.

"(B) Craniofacial abnormalities with at least 2 of the following: microphthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, and short upturned nose.

"(C) Prenatal or postnatal growth delay.

"(8) PARTIAL FAS.—The term 'partial FAS' with respect to an individual means a history of maternal alcohol consumption during pregnancy having most of the criteria of FAS, though not meeting a minimum of at least 2 of the following: micro-ophthalmia, short palpebral fissures, poorly developed philtrum, thin upper lip, flat nasal bridge, short upturned nose.

"(9) REHABILITATION.—The term 'rehabilitation' means to restore the ability or capacity to en-

gage in usual and customary life activities through education and therapy.–

"(10) SUBSTANCE ABUSE.—The term 'substance abuse' includes inhalant abuse. —

"SEC. 715. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.

"TITLE VIII—MISCELLANEOUS

"SEC. 801. REPORTS.

"The President shall, at the time the budget is submitted under section 1105 of title 31, United States Code, for each fiscal year transmit to the Congress a report containing—

"(1) a report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to this Act and an assessment and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which are at a parity with the health services available to and the health status of, the general population, including specific comparisons of appropriations provided and those required for such parity;

"(2) a report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have had an impact on the purposes of this Act and any steps that the Secretary may have taken to consult with Indian tribes to address such impact, including a report on proposed changes in the allocation of funding pursuant to section 808;

"(3) a report on the use of health services by Indians—

"(A) on a national and area or other relevant geographical basis;

"(B) by gender and age;

"(C) by source of payment and type of service;

"(D) comparing such rates of use with rates of use among comparable non-Indian populations; and

"(E) on the services provided under funding agreements pursuant to the Indian Self-Determination and Education Assistance Act;

"(4) a report of contractors concerning health care educational loan repayments under section 110;

"(5) a general audit report on the health care educational loan repayment program as required under section 110(n);

"(6) a separate statement that specifies the amount of funds requested to carry out the provisions of section 201;

"(7) a report on infectious diseases as required under section 212;

"(8) a report on environmental and nuclear health hazards as required under section 214;

"(9) a report on the status of all health care facilities needs as required under sections 301(c)(2) and 301(d);

"(10) a report on safe water and sanitary waste disposal facilities as required under section 302(h)(1);

"(11) a report on the expenditure of non-service funds for renovation as required under sections 305(a)(2) and 305(a)(3);

"(12) a report identifying the backlog of maintenance and repair required at Service and tribal facilities as required under section 314(a);

"(13) a report providing an accounting of reimbursement funds made available to the Secretary

under titles XVIII and XIX of the Social Security Act as required under section 403(a);

"(14) a report on services sharing of the Service, the Department of Veteran's Affairs, and other Federal agency health programs as required under section 412(c)(2);

"(15) a report on the evaluation and renewal of urban Indian programs as required under section 505;

"(16) a report on the findings and conclusions derived from the demonstration project as required under section 512(a)(2);

"(17) a report on the evaluation of programs as required under section 513; and

"(18) a report on alcohol and substance abuse as required under section 701(f).

"SEC. 802. REGULATIONS.

"(a) INITIATION OF RULEMAKING PROCEDURES.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations or amendments thereto that are necessary to carry out this Act.

"(2) PUBLICATION.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary not later than 270 days after the date of enactment of this Act and shall have not less than a 120 day comment period.

"(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under this Act shall expire 18 months from the date of enactment of this Act.

"(b) RULEMAKING COMMITTEE.—A negotiated rulemaking committee established pursuant to section 565 of Title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian tribes, and tribal organizations, a majority of whom shall be nominated by and be representatives of Indian tribes, tribal organizations, and urban Indian organizations from each service area.

"(c) ADAPTION OF PROCEDURES.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian Tribes.

"(d) FAILURE TO PROMULGATE REGULATIONS.—The lack of promulgated regulations shall not limit the effect of this Act.

"(e) SUPREMACY OF PROVISIONS.—The provisions of this Act shall supersede any conflicting provisions of law (including any conflicting regulations) in effect on the day before the date of enactment of the Indian Self-Determination Contract Reform Act of 1994, and the Secretary is authorized to repeal any regulation that is inconsistent with the provisions of this Act.

"SEC. 803. PLAN OF IMPLEMENTATION.

"Not later than 240 days after the date of enactment of this Act, the Secretary, in consultation with Indian tribes, tribal organizations, and urban Indian organizations, shall prepare and submit to Congress a plan that shall explain the manner and schedule (including a schedule of appropriate requests), by title and section, by which the Secretary will implement the provisions of this Act.

"SEC. 804. AVAILABILITY OF FUNDS.

"Amounts appropriated under this Act shall remain available until expended.

"SEC. 805. LIMITATION ON USE OF FUNDS APPROPRIATED TO THE INDIAN HEALTH SERVICE.

"Any limitation on the use of funds contained in an Act providing appropriations for the Department for a pe-

riod with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Service.

"SEC. 806. ELIGIBILITY OF CALIFORNIA INDIANS.

"(a) ELIGIBILITY.—

"(1) IN GENERAL.—Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

"(1) Any member of a Federally recognized Indian tribe.

"(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant—

"(A) is a member of the Indian community served by a local program of the Service; and

"(B) is regarded as an Indian by the community in which such descendant lives.

"(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

"(4) Any Indian in California who is listed on the plans for distribution of the assets of

California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

"(b) RULE OF CONSTRUCTION.—Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

"SEC. 807. HEALTH SERVICES FOR INELIGIBLE PERSONS.

"(a) INELIGIBLE PERSONS.—

"(1) IN GENERAL.—Any individual who—

"(A) has not attained 19 years of age;

"(B) is the natural or adopted child, stepchild, foster-child, legal ward, or orphan of an eligible Indian; and

"(C) is not otherwise eligible for the health services provided by the Service,

shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age. The existing and potential health needs of all such individuals shall be taken into consideration by the Service in determining the need for, or the allocation of, the health resources of the Service. If such an individual has

been determined to be legally incompetent prior to attaining 19 years of age, such individual shall remain eligible for such services until one year after the date such disability has been removed.

"(2) SPOUSES.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all of such spouses or spouses who are married to members of the Indian tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian tribe or tribal organization providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining the need for, or allocation of, its health resources.

"(b) PROGRAMS AND SERVICES.—

"(1) PROGRAMS.—

"(A) IN GENERAL.—The Secretary may provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the service area of a service unit and who are not eligible for such health services under any other

subsection of this section or under any other provision of law if—

"(i) the Indian tribe (or, in the case of a multi-tribal service area, all the Indian tribes) served by such service unit requests such provision of health services to such individuals; and

"(ii) the Secretary and the Indian tribe or tribes have jointly determined that—

"(I) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

"(II) there is no reasonable alternative health program or services, within or without the service area of such service unit, available to meet the health needs of such individuals.

"(B) FUNDING AGREEMENTS.—In the case of health programs operated under a funding agreement entered into under the Indian Self-Determination and Educational Assistance Act, the governing body of the Indian tribe or tribal organization providing health services under

such funding agreement is authorized to determine whether health services should be provided under such funding agreement to individuals who are not eligible for such health services under any other subsection of this section or under any other provision of law. In making such determinations, the governing body of the Indian tribe or tribal organization shall take into account the considerations described in subparagraph (A)(ii).

"(2) LIABILITY FOR PAYMENT.—

"(A) IN GENERAL.—Persons receiving health services provided by the Service by reason of this subsection shall be liable for payment of such health services under a schedule of charges prescribed by the Secretary which, in the judgment of the Secretary, results in reimbursement in an amount not less than the actual cost of providing the health services. Notwithstanding section 1880(c) of the Social Security Act, section 402(a) of this Act, or any other provision of law, amounts collected under this subsection, including medicare or medicaid reimbursements under titles XVIII and XIX of the Social Security Act, shall be credited to the

account of the program providing the service and shall be used solely for the provision of health services within that program. Amounts collected under this subsection shall be available for expenditure within such program for not to exceed 1 fiscal year after the fiscal year in which collected.

"(B) SERVICES FOR INDIGENT PERSONS.—Health services may be provided by the Secretary through the Service under this subsection to an indigent person who would not be eligible for such health services but for the provisions of paragraph (1) only if an agreement has been entered into with a State or local government under which the State or local government agrees to reimburse the Service for the expenses incurred by the Service in providing such health services to such indigent person.

"(3) SERVICE AREAS.—

"(A) SERVICE TO ONLY ONE TRIBE.—In the case of a service area which serves only one Indian tribe, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which the governing

body of the Indian tribe revokes its concurrence to the provision of such health services.

"(B) MULTI-TRIBAL AREAS.—In the case of a multi-tribal service area, the authority of the Secretary to provide health services under paragraph (1)(A) shall terminate at the end of the fiscal year succeeding the fiscal year in which at least 51 percent of the number of Indian tribes in the service area revoke their concurrence to the provision of such health services.

"(c) PURPOSE FOR PROVIDING SERVICES.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other subsection of this section or under any other provision of law in order to—

"(1) achieve stability in a medical emergency;

"(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

"(3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post partum; or

"(4) provide care to immediate family members of an eligible person if such care is directly related to the treatment of the eligible person.

"(d) HOSPITAL PRIVILEGES.—Hospital privileges in health facilities operated and maintained by the Service or operated under a contract entered into under the Indian Self-Determination Education Assistance Act may be extended to non-Service health care practitioners who provide services to persons described in subsection (a) or (b). Such non-Service health care practitioners may be regarded as employees of the Federal Government for purposes of section 1346(b) and chapter 171 of title 28, United States Code (relating to Federal tort claims) only with respect to acts or omissions which occur in the course of providing services to eligible persons as a part of the conditions under which such hospital privileges are extended.

"(e) DEFINITION.—In this section, the term 'eligible Indian' means any Indian who is eligible for health services provided by the Service without regard to the provisions of this section.

"SEC. 806. REALLOCATION OF BASE RESOURCES.

"(a) REQUIREMENT OF REPORT.—Notwithstanding any other provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a service unit may be implemented only after the Secretary has submitted to the

President, for inclusion in the report required to be transmitted to the Congress under section 801, a report on the proposed change in allocation of funding, including the reasons for the change and its likely effects.

"(b) NONAPPLICATION OF SECTION.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is less than the amount appropriated to the Service for previous fiscal year.

"SEC. 809. RESULTS OF DEMONSTRATION PROJECTS.

"The Secretary shall provide for the dissemination to Indian tribes of the findings and results of demonstration projects conducted under this Act.

"SEC. 810. PROVISION OF SERVICES IN MONTANA.

"(a) IN GENERAL.—The Secretary, acting through the Service, shall provide services and benefits for Indians in Montana in a manner consistent with the decision of the United States Court of Appeals for the Ninth Circuit in McNabb for McNabb v. Bowen, 829 F.2d 787 (9th Cr. 1987).

"(b) RULE OF CONSTRUCTION.—The provisions of subsection (a) shall not be construed to be an expression of the sense of the Congress on the application of the decision described in subsection (a) with respect to the provision of services or benefits for Indians living in any State other than Montana.

"SEC. 811. MORATORIUM.

"During the period of the moratorium imposed by Public Law 100–446 on implementation of the final rule published in the Federal Register on September 16, 1987, by the Health Resources and Services Administration, relating to eligibility for the health care services of the Service, the Service shall provide services pursuant to the criteria for eligibility for such services that were in effect on September 15, 1987, subject to the provisions of sections 806 and 807 until such time as new criteria governing eligibility for services are developed in accordance with section 802.

"SEC. 812. TRIBAL EMPLOYMENT.

"For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, Chapter 372), an Indian tribe or tribal organization carrying out a funding agreement under the Self-Determination and Education Assistance Act shall not be considered an employer.

"SEC. 813. PRIME VENDOR.

"For purposes of section 4 of Public Law 102–585 (38 U.S.C. 812) Indian tribes and tribal organizations carrying out a grant, cooperative agreement, or funding agreement under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall be deemed to be an executive agency and part of the Service in the and, as such, may act as an ordering agent of the

Service and the employees of the tribe or tribal organization may order supplies on behalf thereof on the same basis as employees of the Service.

"SEC. 814. NATIONAL BI-PARTISAN COMMISSION ON INDIAN HEALTH CARE ENTITLEMENT.

"(a) ESTABLISHMENT.—There is hereby established the National Bi-Partisan Indian Health Care Entitlement Commission (referred to in this Act as the 'Commission').

"(b) MEMBERSHIP.—The Commission shall be composed of 25 members, to be appointed as follows:

"(1) Ten members of Congress, of which—

"(A) three members shall be from the House of Representatives and shall be appointed by the majority leader;

"(B) three members shall be from the House of Representatives and shall be appointed by the minority leader;

"(C) two members shall be from the Senate and shall be appointed by the majority leader; and

"(D) two members shall be from the Senate and shall be appointed by the minority leader;

who shall each be members of the committees of Congress that consider legislation affecting the pro-

vision of health care to Indians and who shall elect the chairperson and vice-chairperson of the Commission.

"(2) Twelve individuals to be appointed by the members of the Commission appointed under paragraph (1), of which at least 1 shall be from each service area as currently designated by the Director of the Service, to be chosen from among 3 nominees from each such area as selected by the Indian tribes within the area, with due regard being given to the experience and expertise of the nominees in the provision of health care to Indians and with due regard being given to a reasonable representation on the Commission of members who are familiar with various health care delivery modes and who represent tribes of various size populations.

"(3) Three individuals shall be appointed by the Director of the Service from among individual who are knowledgeable about the provision of health care to Indians, at least 1 of whom shall be appointed from among 3 nominees from each program that is funded in whole or in part by the Service primarily or exclusively for the benefit of urban Indians.

All those persons appointed under paragraphs (2) and (3) shall be members of Federally recognized Indian Tribes.

"(c) TERMS.—

"(1) IN GENERAL.—Members of the Commission shall serve for the life of the Commission.

"(2) APPOINTMENT OF MEMBERS.—Members of the Commission shall be appointed under subsection (b)(1) not later than 90 days after the date of enactment of this Act, and the remaining members of the Commission shall be appointed not later than 60 days after the date on which the members are appointed under such subsection.

"(3) VACANCY.—A vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made.

"(d) DUTIES OF THE COMMISSION.—The Commission shall carry out the following duties and functions:

"(1) Review and analyze the recommendations of the report of the study committee established under paragraph (3) to the Commission.

"(2) Make recommendations to Congress for providing health services for Indian persons as an entitlement, giving due regard to the effects of such a programs on existing health care delivery systems for Indian persons and the effect of such programs on the sovereign status of Indian Tribes;

"(3) Establish a study committee to be composed of those members of the Commission appointed by the Director of the Service and at least 4 additional members of Congress from among the members of the Commission which shall—

"(A) to the extent necessary to carry out its duties, collect and compile data necessary to understand the extent of Indian needs with regard to the provision of health services, regardless of the location of Indians, including holding hearings and soliciting the views of Indians, Indian tribes, tribal organizations and urban Indian organizations, and which may include authorizing and funding feasibility studies of various models for providing and funding health services for all Indian beneficiaries including those who live outside of a reservation, temporarily or permanently;

"(B) make recommendations to the Commission for legislation that will provide for the delivery of health services for Indians as an entitlement, which shall, at a minimum, address issues of eligibility, benefits to be provided, including recommendations regarding from whom such health services are to be provide,d and the

cost, including mechanisms for funding of the health services to be provided;

"(C) determine the effect of the enactment of such recommendations on the existing system of the delivery of health services for Indians;

"(D) determine the effect of a health services entitlement program for Indian persons on the sovereign status of Indian tribes;

"(E) not later than 12 months after the appointment of all members of the Commission, make a written report of its findings and recommendations to the Commission, which report shall include a statement of the minority and majority position of the committee and which shall be disseminated, at a minimum, to each Federally recognized Indian tribe, tribal organization and urban Indian organization for comment to the Commission; and

"(F) report regularly to the full Commission regarding the findings and recommendations developed by the committee in the course of carrying out its duties under this section.

"(4) Not later than 18 months after the date of appointment of all members of the Commission, submit a written report to Congress containing a

recommendation of policies and legislation to implement a policy that would establish a health care system for Indians based on the delivery of health services as an entitlement, together with a determination of the implications of such an entitlement system on existing health care delivery systems for Indians and on the sovereign status of Indian tribes.

"(e) ADMINISTRATIVE PROVISIONS.—

"(1) COMPENSATION AND EXPENSES.—

"(A) CONGRESSIONAL MEMBERS.—Each member of the Commission appointed under subsection (b)(1) shall receive no additional pay, allowances, or benefits by reason of their service on the Commission and shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

"(B) OTHER MEMBERS.—The members of the Commission appointed under paragraphs (2) and (3) of subsection (b), while serving on the business of the Commission (including travel time) shall be entitled to receive compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States

Code, and while so serving away from home and the member's regular place of business, be allowed travel expenses, as authorized by the chairperson of the Commission. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(2) MEETINGS AND QUORUM.—

"(A) MEETINGS.—The Commission shall meet at the call of the chairperson.

"(B) QUORUM.—A quorum of the Commission shall consist of not less than 15 members, of which not less than 6 of such members shall be appointees under subsection (b)(1) and not less than 9 of such members shall be Indians.

"(3) DIRECTOR AND STAFF.—

"(A) EXECUTIVE DIRECTOR.—The members of the Commission shall appoint an executive director of the Commission. The executive director shall be paid the rate of basic pay equal to that for level V of the Executive Schedule.

"(B) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director deems appropriate.

"(C) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

"(D) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

"(E) FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals

required for the proper functioning of the Commission.

"(f) POWERS.—

"(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties, except that at least 6 regional hearings shall be held in different areas of the United States in which large numbers of Indians are present. Such hearings shall be held to solicit the views of Indians regarding the delivery of health care services to them. To constitute a hearing under this paragraph, at least 5 members of the Commission, including at least 1 member of Congress, must be present. Hearings held by the study committee established under this section may be counted towards the number of regional hearings required by this paragraph.

"(2) STUDIES BY GAO.—Upon request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

"(3) COST ESTIMATES.—

"(A) IN GENERAL.—The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

"(B) REIMBURSEMENTS.—The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

"(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any federal Agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the federal employee.

"(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal Agency shall provide such technical assistance to the

Commission as the Commission determines to be necessary to carry out its duties.

"(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal Agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

"(7) OBTAINING INFORMATION.—The Commission may secure directly from the any Federal Agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 4, United States Code. Upon request of the chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

"(8) SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

"(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Of-

fice, the Commission shall be deemed to be a committee of the Congress.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $4,000,000 to carry out this section. The amount appropriated under this subsection shall not be deducted from or affect any other appropriation for health care for Indian persons.

"SEC. 815. APPROPRIATIONS; AVAILABILITY.

"Any new spending authority (described in subsection (c)(2)(A) or (B) of section 401 of the Congressional Budget Act of 1974) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

"SEC. 816. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary for each fiscal year through fiscal year 2012 to carry out this title.".

TITLE II—CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

Subtitle A—Medicare

SEC. 201. LIMITATIONS ON CHARGES.

Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by adding a semicolon at the end;

(2) in subparagraph (S), by striking the period and inserting "; and"; and

(3) by adding at the end the following:

"(T) in the case of hospitals and critical access hospitals which provide inpatient hospital services for which payment may be made under this title, to accept as payment in full for services that are covered under and furnished to an individual eligible for the contract health services program operated by the Indian Health Service, by an Indian tribe or tribal organization, or furnished to an urban Indian eligible for health services purchased by an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), in accordance with such admission practices and such payment methodology and amounts as are prescribed under regulations issued by the Secretary.".

SEC. 202. INDIAN HEALTH PROGRAMS.

Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended to read as follows:

"INDIAN HEALTH PROGRAMS

"SEC. 1880. (a) ELIGIBILITY FOR PAYMENTS.—The Indian Health Service (referred to in this section as the 'Service') and an Indian tribe or tribal organization, or

an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the Service, Indian tribe or tribal organization, or urban Indian organization meets the conditions and requirements for such payments which are applicable generally to the service or provider type for which the Service, Indian tribe or tribal organization, or urban Indian organization seeks payment under this title and for services and provider types provided by a qualified Indian health program under section 1880A.

"(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Service, an Indian tribe or tribal organization, or urban Indian organization, does not meet all of the conditions and requirements of this title which are applicable generally to the service or provider type for which payment is sought, but submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compli-

ance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

"(c) DIRECT BILLING.—For provisions relating to the authority of certain Indian tribes and tribal organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or tribal organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act.

"(d) COMMUNITY HEALTH AIDES.—The Service or an Indian Tribe or tribal organization providing a service otherwise eligible for payment under this section through the use of a community health aide or practitioner certified under the provisions of section 121 of the Indian Health Care Improvement Act shall be paid for such services on the same basis that such services are reimbursed under State plans approved under title XIX.

"(e) TREATMENT OF CERTAIN PROGRAMS.—Notwithstanding any other provision of law, a health program operated by the Service or an Indian tribe or tribal organization, which collaborates with a hospital operated by the Service or an Indian tribe or tribal organization, shall, at the option of the Indian tribe or tribal organization, be paid for services for which it would otherwise be eligible

for under this as if the health program were an outpatient department of the hospital. In situations where the health program is on a separate campus from the hospital, billing as an outpatient department of the hospital shall not subject such a health program to the requirements of section 1867.

"(f) PAYMENT FOR CERTAIN NURSING SERVICES.—The Service or an Indian tribe or tribal organization providing visiting nurse services in a home health agency shortage area shall be paid for such services on the same basis that such services are reimbursed under this title for other primary care providers.

"(g) ALTERNATIVE METHODS OF REIMBURSEMENT.—Notwithstanding any other provision of law, the Secretary may identify and implement alternative methods of reimbursing Indian health programs for services reimbursable under this title that are provided to Indians, so long as such methods—

"(1) allow an Indian tribe or tribal organization or urban Indian organization to opt to receive reimbursement under reimbursement methodologies applicable to other providers of similar services; and

"(2) provide that the amount of reimbursement resulting under any such methodology shall not be less than 100 percent of the reasonable cost of the

service to which the methodology applies under section 1861(v).".

SEC. 203. QUALIFIED INDIAN HEALTH PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1880 the following:

"QUALIFIED INDIAN HEALTH PROGRAM

"SEC. 1880A. (a) DEFINITION OF QUALIFIED INDIAN HEALTH PROGRAM.—In this section:

"(1) IN GENERAL.—The term 'qualified Indian health program' means a health program operated by—

"(A) the Indian Health Service;

"(B) an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act) and which is funded in whole or part by the Indian Health Service under the Indian Self Determination and Education Assistance Act; and

"(C) an urban Indian organization (as so defined) and which is funded in whole or in part under title V of the Indian Health Care Improvement Act.

"(2) INCLUDED PROGRAMS AND ENTITIES.—Such term may include 1 or more hospital, nursing

home, home health program, clinic, ambulance service or other health program that provides a service for which payments may be made under this title and which is covered in the cost report submitted under this title or title XIX for the qualified Indian health program.

"(b) ELIGIBILITY FOR PAYMENTS.—A qualified Indian health program shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as the program meets all the conditions and requirements set forth in this section.

"(c) DETERMINATION OF PAYMENTS.—

"(1) IN GENERAL.—Notwithstanding any other provision in the law, a qualified Indian health program shall be entitled to receive payment based on an all-inclusive rate which shall be calculated to provide full cost recovery for the cost of furnishing services provided under this section.

"(2) DEFINITION OF FULL COST RECOVERY.—

"(A) IN GENERAL.—Subject to subparagraph (B), in this section, the term 'full cost recovery' means the sum of—

"(i) the direct costs, which are reasonable, adequate and related to the cost of furnishing such services, taking into ac-

count the unique nature, location, and service population of the qualified Indian health program, and which shall include direct program, administrative, and overhead costs, without regard to the customary or other charge or any fee schedule that would otherwise be applicable; and

"(ii) indirect costs which, in the case of a qualified Indian health program—

"(I) for which an indirect cost rate (as that term is defined in section 4(g) of the Indian Self-Determination and Education Assistance Act) has been established, shall be not less than an amount determined on the basis of the indirect cost rate; or

"(II) for which no such rate has been established, shall be not less than the administrative costs specifically associated with the delivery of the services being provided.

"(B) LIMITATION.—Notwithstanding any other provision of law, the amount determined to be payable as full cost recovery may not be reduced for co-insurance, co-payments, or

deductibles when the service was provided to an Indian entitled under Federal law to receive the service from the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization or because of any limitations on payment provided for in any managed care plan.

"(3) OUTSTATIONING COSTS.—In addition to full cost recovery, a qualified Indian health program shall be entitled to reasonable outstationing costs, which shall include all administrative costs associated with outreach and acceptance of eligibility applications for any Federal or State health program including the programs established under this title, title XIX, and XXI.

"(4) DETERMINATION OF ALL-INCLUSIVE ENCOUNTER OR PER DIEM AMOUNT.—

"(A) IN GENERAL.—Costs identified for services addressed in a cost report submitted by a qualified Indian health program shall be used to determine an all-inclusive encounter or per diem payment amount for such services.

"(B) NO SINGLE REPORT REQUIREMENT.—Not all health programs provided or administered by the Indian Health Service, an

Indian tribe or tribal organization, or an urban Indian organization need be combined into a single cost report.

"(C) PAYMENT FOR ITEMS NOT COVERED BY A COST REPORT.—A full cost recovery payment for services not covered by a cost report shall be made on a fee-for-service, encounter, or per diem basis.

"(5) OPTIONAL DETERMINATION.—The full cost recovery rate provided for in paragraphs (1) through (3) may be determined, at the election of the qualified Indian health program, by the Health Care Financing Administration or by the State agency responsible for administering the State plan under title XIX and shall be valid for reimbursements made under this title, title XIX, and title XXI. The costs described in paragraph (2)(A) shall be calculated under whatever methodology yields the greatest aggregate payment for the cost reporting period, provided that such methodology shall be adjusted to include adjustments to such payment to take into account for those qualified Indian health programs that include hospitals—

"(A) a significant decrease in discharges;

"(B) costs for graduate medical education programs;

"(C) additional payment as a disproportionate share hospital with a payment adjustment factor of 10; and

"(D) payment for outlier cases.

"(6) ELECTION OF PAYMENT.—A qualified Indian health program may elect to receive payment for services provided under this section—

"(A) on the full cost recovery basis provided in paragraphs (1) through (5);

"(B) on the basis of the inpatient or outpatient encounter rates established for Indian Health Service facilities and published annually in the Federal Register;

"(C) on the same basis as other providers are reimbursed under this title, provided that the amounts determined under paragraph (c)(2)(B) shall be added to any such amount;

"(D) on the basis of any other rate or methodology applicable to the Indian Health Service or an Indian Tribe or tribal organization; or

"(E) on the basis of any rate or methodology negotiated with the agency responsible for making payment.

"(d) ELECTION OF REIMBURSEMENT FOR OTHER SERVICES.—

"(1) IN GENERAL.—A qualified Indian health program may elect to be reimbursed for any service the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization may be reimbursed for under section 1880 and section 1911.

"(2) OPTION TO INCLUDE ADDITIONAL SERVICES.—An election under paragraph (1) may include, at the election of the qualified Indian health program—

"(A) any service when furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service to the same extent that such service would be reimbursable if performed by a physician and any service or supplies furnished as incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service;

"(B) screening, diagnostic, and therapeutic outpatient services including part-time or intermittent screening, diagnostic, and therapeutic skilled nursing care and related medical supplies (other than drugs and biologicals), furnished by an employee of the qualified Indian health program who is licensed or certified to perform such a service for an individual in the individual's home or in a community health setting under a written plan of treatment established and periodically reviewed by a physician, when furnished to an individual as an outpatient of a qualified Indian health program;

"(C) preventive primary health services as described under sections 329, 330, and 340 of the Public Health Service Act, when provided by an employee of the qualified Indian health program who is licensed or certified to perform such a service, regardless of the location in which the service is provided;

"(D) with respect to services for children, all services specified as part of the State plan under title XIX, the State child health plan under title XXI, and early and periodic screen-

ing, diagnostic, and treatment services as described in section 1905(r);

"(E) influenza and pneumococcal immunizations;

"(F) other immunizations for prevention of communicable diseases when targeted; and

"(G) the cost of transportation for providers or patients necessary to facilitate access for patients.".

Subtitle B—Medicaid

SEC. 211. PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.

Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended—

(1) in subparagraph (B), by striking "and" at the end;

(2) in subparagraph (C), by adding "and" at the end; and

(3) by adding at the end the following:

"(D)(i) for payment for services described in section 1905(a)(2)(C) under the plan furnished by an Indian tribe or tribal organization or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) of 100 percent of costs which are

reasonable and related to the cost of furnishing such services or based on other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, the same methodology used under section 1833(a)(3), and

"(ii) in the case of such services furnished pursuant to a contract between a Federally-qualified health center and a medicaid managed care organization under section 1903(m), for payment to the Federally-qualified health center at least quarterly by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract.".

SEC. 212. STATE CONSULTATION WITH INDIAN HEALTH PROGRAMS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (65), by striking the period; and

(2) by inserting after (65), the following:

"(66) if the Indian Health Service operates or funds health programs in the State or if there are Indian tribes or tribal organizations or urban Indian organizations (as those terms are defined in Section 4 of the Indian Health Care Improvement Act) present in the State, provide for meaningful consultation with such entities prior to the submission of, and as a precondition of approval of, any proposed amendment, waiver, demonstration project, or other request that would have the effect of changing any aspect of the State's administration of the State plan under this title, so long as—

"(A) the term 'meaningful consultation' is defined through the negotiated rulemaking process provided for under section 802 of the Indian Health Care Improvement Act; and

"(B) such consultation is carried out in collaboration with the Indian Medicaid Advisory Committee established under section 415(a)(3) of that Act.".

SEC. 213. FMAP FOR SERVICES PROVIDED BY INDIAN HEALTH PROGRAMS.

The third sentence of Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended to read as follows:

"Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per cent with respect to amounts expended as medical assistance for services which are received through the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) under section 1911, whether directly, by referral, or under contracts or other arrangements between the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization and another health provider.".

SEC. 214. INDIAN HEALTH SERVICE PROGRAMS.

Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended to read as follows:

"INDIAN HEALTH SERVICE PROGRAMS

"SEC. 1911. (a) IN GENERAL.—The Indian Health Service and an Indian tribe or tribal organization or an urban Indian organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as such Service, Indian tribe or tribal organization, or urban Indian organization provides services or provider types of a type otherwise covered under the State plan and meets the conditions and requirements which are applicable generally to the service for which it seeks reimbursement

under this title and for services provided by a qualified Indian health program under section 1880A.

"(b) PERIOD FOR BILLING.—Notwithstanding subsection (a), if the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization which provides services of a type otherwise covered under the State plan does not meet all of the conditions and requirements of this title which are applicable generally to such services submits to the Secretary within 6 months after the date on which such reimbursement is first sought an acceptable plan for achieving compliance with such conditions and requirements, the Service, an Indian tribe or tribal organization, or urban Indian organization shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of actual compliance with such conditions and requirements during the first 12 months after the month in which such plan is submitted.

"(c) AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided by the Indian Health Service, Indian tribes or tribal organizations and urban Indian organizations, directly, through referral, or under contracts or other arrangements between the Indian

Health Service, an Indian tribe or tribal organization, or an urban Indian organization and another health care provider to Indians who are eligible for medical assistance under the State plan.

Subtitle C—State Children's Health Insurance Program

SEC. 221. ENHANCED FMAP FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended—

(1) by striking "For purposes" and inserting the following:

"(1) IN GENERAL.—Subject to paragraph (2), for purposes"; and

(2) by adding at the end the following:

"(2) SERVICES PROVIDED BY INDIAN PROGRAMS.—Without regard to which option a State chooses under section 2101(a), the 'enhanced FMAP' for a State for a fiscal year shall be 100 per cent with respect to expenditures for child health assistance for services provided through a health program operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act).".

(b) CONFORMING AMENDMENT.—Section 2105(c)(6)(B) of such Act (42 U.S.C. 1397ee(c)(6)(B)) is amended by inserting "an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act)" after "Service".

SEC. 222. DIRECT FUNDING OF STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

Title XXI of Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

"SEC. 2111. DIRECT FUNDING OF INDIAN HEALTH PROGRAMS.

"(a) IN GENERAL.—The Secretary may enter into agreements directly with the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act) for such entities to provide child health assistance to Indians who reside in a service area on or near an Indian reservation. Such agreements may provide for funding under a block grant or such other mechanism as is agreed upon by the Secretary and the Indian Health Service, Indian tribe or tribal organization, or urban Indian organization. Such agreements may not be made contingent on the approval of the State in which the Indians to be served reside.

"(b) TRANSFER OF FUNDS.—Notwithstanding any other provision of law, a State may transfer funds to which it is, or would otherwise be, entitled to under this title to the Indian Health Service, an Indian tribe or tribal organization or an urban Indian organization—

"(1) to be administered by such entity to achieve the purposes and objectives of this title under an agreement between the State and the entity; or

"(2) under an agreement entered into under subsection (a) between the entity and the Secretary.".

Subtitle D—Authorization of Appropriations

SEC. 231. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2000 through 2012 to carry out this title and the amendments by this title.

TITLE III—MISCELLANEOUS PROVISIONS

SEC. 301. REPEALS.

The following are repealed:

(1) Section 506 of Public Law 101–630 (25 U.S.C. 1653 note) is repealed.

(2) Section 712 of the Indian Health Care Amendments of 1988 is repealed.

SEC. 302. SEVERABILITY PROVISIONS.

If any provision of this Act, any amendment made by the Act, or the application of such provision or amendment to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

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The CHAIRMAN. Our panel will be John Callahan, assistant secretary, Management and Budget, Department of Health and Human Services; Melissa McNiel, Cherokee Nation of Oklahoma; Barbara Namias, director, Community Health Program, North American Indian Center in Boston; and Denis Turner, South California Tribal Chairmen's Association. If you would come to the floor.

Okay, if we could move on with this panel. We have a very limited time, as I mentioned to the first panel. And if our guests could be seated.

We'll start with John Callahan, assistant secretary, Management and Budget for the Department of Health and Human Services.

STATEMENT OF JOHN CALLAHAN, ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. CALLAHAN. Thank you, Chairman Campbell.

I have a full statement for the record.

The CHAIRMAN. Yes; we'll include that in the record. And if you would limit your comments to what this little light up here says, I would appreciate it.

Mr. CALLAHAN. Right. I want to thank you and Senator Inouye, the ranking member, for inviting us here today.

With regard to my oral statement, we want to commend the committee for moving this legislation forward. It basically is done in the process of tribal consultation, which as you know, the Department has taken the lead among many departments of having a strong tribal consultation process with regard to our budget and all our policies. So we commend you in that regard.

Our detailed statement indicates the Department's views on many of the provisions in S. 2526. Let me say at the outset, we are very supportive of a number of the provisions including the elevation of the Director of IHS, Dr. Trujillo, to the position of Assistant Secretary of Indian Health. And we also support many of the advances in the bill, particularly those dealing with diabetes funding, which the President has proposed to continue at a level of $30 million a year, as well as other authorizations for infectious disease and the modernization and establishment of epidemiological centers in Indian Country.

We're also encouraged by the provisions of the bill that talk about expanded authorizations for health services to urban Indians. We do know a number of urban Indians receive health services off the reservation, but there are many more that could receive those services, and we are supportive of many of the efforts that you're making in that regard.

There are a number of provisions in the bill, both in title III and title IV, that we feel need further consideration by the committee. In title III, in the area of facilities, the requirements to come forward with an annual facility plan, the additional burden that would cause, over and above the current priority list that the IHS develops, would be something that we'd have to look at carefully. But there are also further fiscal and feasibility analyses that have to be taken with regard to the loan guarantee and loan repayment programs, that are also proposed in the bill.

With regard to title IV, which is Medicaid and Medicare amendments, we would remind the committee that within the last 4 or 5 years, we have worked very closely together, with HCFA and IHS, to provide up to date and streamlined reimbursements for Medicare and Medicaid to IHS. This has resulted in an increase of $196 million flowing to IHS facilities.

We also had the proposal, as you know, which you've adopted, where there should be no premium and cost sharing for American Indian children under the SCHIP program. At the same time, we must make note that the public health service programs that are run by IHS and Medicare and Medicaid are in many ways distinctly different programs. Medicare and Medicaid have distinct rules about payments and eligibility. And we would like to work further with the committee about the problems that we see in that part of the bill.

Also we would say on negotiated rulemaking, as the committee knows, oftentimes that can be very constructive. But it has to be done in oftentimes a circumscribed manner, so that you will get to the end, you will have a consensus on negotiated rulemaking and not just have continuous meetings without any progress whatsoever. That would not be helpful either to the American Indian community or to the providers.

But let me end on a positive note, Chairman Campbell. We think that S. 2526 is a very, very positive step in the right direction. The Department and the Administration is committed to working with the committee in further consultation in those areas where we still have some questions. So we would like to thank you for your efforts in that regard.

[Prepared statement of Mr. Callahan appears in appendix.]

The CHAIRMAN. Well, thank you for that support.

I would remind you that we introduced this in May, as I remember. But it's my understanding that we sent you some paperwork on it to review the bill 10 months ago. And so if we do that again, I would hope you would get back to us earlier and give us some input on it.

And with that, oh, by the way, Dr. Trujillo, are you here as a resource person for Mr. Callahan?

Mr. TRUJILLO. Yes; I am.

The CHAIRMAN. All right, so we'll go ahead to Ms. McNiel, then.

STATEMENT OF MELISSA McNIEL, EXECUTIVE OFFICER, OFFICE OF PRINCIPAL CHIEF, CHEROKEE NATION

Ms. MCNIEL. Thank you. Good afternoon, Senator Campbell, Senator Inouye and members of the committee.

I am Melissa McNiel, the executive officer of the Cherokee Nation. And I am here today to deliver Cherokee Nation's strong support for S. 2526. As you know, Cherokee Nation is the second largest tribe with over 213,000 tribal members. We were one of the first tribes to enter into a self-determination contract and a self-governance compact to deliver our health care services.

We operate six outpatient clinics with very limited resources. By operating our own health care system, we have been able to reduce the Federal bureaucracy, enhance local control and make efficiency

improvements which have allowed us to better meet the needs of our tribal members.

As I look around this room today and see many friends, I want to tell each of you that Cherokee Nation applauds your many efforts in addressing the unmet health care needs in Indian Country. You have once again done this through the introduction of this legislation, and we appreciate that.

We believe that this bill not only strengthens the tribes, but it also enables Indian Health Service and health agencies to better serve tribal members. We believe it helps the Federal agencies to become true partners, strong advocates and helpful resources for all tribes. We are pleased that the tone of this bill is that the health status objectives for Indians should be at least as good as the U.S. population as a whole.

The focus of my testimony today is title IV, which provides constructive ways for Indians to benefit from federally-funded health programs, in addition to the Indian Health Service. This is a critical concept, since the funding for Indian health programs does not meet the needs of Indian people.

And now I want to make a few specific recommendations on title IV. We recommend that section 409(c) include language to address the inequalities in health care funding, both in the Federal health system and the Indian health system. These inequalities are documented in the level of need funded study commissioned by Congress and published by Indian Health Service in December 1999.

We recommend that the premiums and copays for Medicare part B be waived in section 419(b)(2) to assure Medicare access for Indian elders.

Also because many Indian elders have lived their entire lives in areas of high unemployment and have not been able to meet the required quarter's work for Medicare eligibility, we recommend that all Indian elders be deemed eligible for Medicare. Medicare coverage for Indian elders is so critical because of the horrifying rate of diabetes. And to illustrate this point a little further, I want to tell you a quick story that our Chief Smith tells about his memorable encounter with diabetes and its effects.

Ruth was a tribal member who he would see from time to time and always enjoyed visiting with her. One time he saw her and she had a foot missing. He asked her why she had a foot missing, and she told him that the doctor had to cut it off due to her having diabetes. The next time he saw her, she had her leg missing. The next time it was the other foot, the other time the other leg.

Then he heard one day that she had passed away. Unfortunately, this story is the rule in Indian Country and not the exception. And we must do more to fight against this horrible disease.

We also recommend a clarification of the wording in section 423(a) to distinguish between public and private health care plans and the tribe's authority to bill the State directly for public health plans. We also recommend that reasonable costs be tied to a specific standard such as not less than the amount Medicare would pay IHS for the same service.

We also have a couple other recommendations in this title that are spelled out in the written testimony that I have submitted and won't go into for a lack of time.

But I want to make two brief statements on title V and title VI. About one-half of Cherokee Nation's tribal members live outside of our service area due to Federal policies that encouraged relocation by the BIA as well as the lack of employment opportunities in rural Oklahoma. We are very glad that the urban programs deliver health services to our urban Indian populations.

All of us in this room has tried to bring national attention and focus to the health status of Indian people. We have had some successes and some failures. We believe that the provisions in title VI will enable us to more effectively advocate for the unmet health care needs in Indian Country.

In conclusion, I just want to say that we believe S. 2526 simply allows Congress to fulfill promises made to tribes and enables tribes to operate their health systems more efficiently. Thank you for this opportunity to testify in support of this very important legislation.

[Prepared statement of Ms. McNiel appears in appendix.]

The CHAIRMAN. Thank you for those important comments on diabetes. I frankly don't know of an Indian family that hasn't been affected by it. You spoke of the lady with the foot that was amputated, my grandmother's stepbrother had his legs cut off three times. That might sound impossible to cut three times with just two legs, but that's what actually happened, is they cut one leg off below the knee, and then they had to cut the other one off, and that still didn't stop it, then they had to cut it off just below the thigh. So he lost his leg three times before he finally passed away.

So it has a devastating effect, not only on the person, but on the whole family, too. So I recognize that. Thanks for those comments.

And please wish our friend, Wilma Mankiller, we hope she's in good health and that retirement does have some virtues.

Ms. MCNIEL. Thank you.

The CHAIRMAN. Thank you.

Barbara, if you'd like to continue, please.

STATEMENT OF BARBARA NAMIAS, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Ms. NAMIAS. Good afternoon, Honorable Chairman and committee members. My name is Barbara Namias. I'm president of the National Council of Urban Indian Health. I'm a member of the St. Regis Mohawk Tribe and also the health director of the North American Indian Center of Boston.

On behalf of NCUIH and its 31 member organizations, I would like to express our appreciation for this opportunity to testify before your committee on the reauthorization of the Indian Health Care Improvement Act.

On March 8, 2000, the former president of NCUIH, Kay Culbertson, presented detailed testimony on the technical aspects of the Indian Health Care Improvement Act. I will not repeat that detailed analysis here. What I would like to do is address certain issues not addressed in the March 8 testimony. In particular, the absence of urban Indian in the Congressional policy statement for S. 2526, the definition of urban Indian and the status of the Oklahoma City Clinic and the Tulsa clinic.

Let me begin by saying that working with the National Steering Committee has been one of my best experiences in Indian Country. We were able to achieve an extraordinary level of consensus, proving that by working together, we can accomplish more than by working separately.

As a result, NCUIH strongly supports the recommendations of the National Steering Committee for the reauthorization of the Indian Health Care Improvement Act, which form the basis of S. 2526. We have raised, however, with the National Steering Committee, certain issues which relate to urban Indians which need to be addressed.

The first issue concerns a Congressional policy statement in S. 2526. The Indian Health Care Improvement Act currently provides that it is the policy of the United States to achieve the highest possible health status to both Indian and urban Indians. The law goes on to say that it is the intent of the Congress that the United States meet certain health objectives with respect to both Indians and urban Indians by the year 2000. This is current law.

For some reason, S. 2526 does not, however, include a reference to urban Indians in the equivalent paragraphs. Removing urban Indians from these important policy statements would imply that the Congress no longer considers the health status of urban Indians to be a national priority. We have been informed that this was an oversight. We strongly urge the restoration of urban Indian to section 3, subsection 1 and 2, of S. 2526.

The second issue relates to the definition of urban Indian was changed in a manner which would eliminate some Indians currently eligible for services at urban Indian programs. This has been explained as an unintended omission, and there has been general consensus on the National Steering Committee to restore the original language.

I would like to comment briefly on why the definition of urban Indian has, since initial passage of the Indian Health Care Improvement Act in 1976, been drafted to reflect the diverse makeup of the urban Indian community. Most urban Indians moved to the cities because of some Federal program or action, including one, the BIA relocation program, which relocated 160,000 Indians to cities between 1953 and 1962. Today, the children, grandchildren and great-grandchildren of these Indians are still in the cities. They maintain their Indian identity even if in some cases they have been unable to re-establish ties, including formal membership with their tribes.

Two, the failure of Federal economic policies on reservations, which has forced many Indians to become economic refugees in the cities. Three, the termination of tribes, many of which have not yet been restored to recognition. Four, the marginalization of tribal communities such that they exist but are not federally recognized.

Five, Indian services in the U.S. military which brought Indians into the urban environment. And six, the General Allotment Act, which made some Indians U.S. citizens, many of whom lost their lands and had to move to nearby cities and towns. Seven, court sanctioned adoption of Indian children by non-Indian families. And eight, boarding schools.

Some of these Federal policies were designed to force assimilation and to break down tribal governments. Others may have been intended, at some misguided level, to benefit Indians but failed miserably.

The result of this course of dealing, however, is the same: The creation of an urban Indian community which is extremely diverse. In a 1976 report, the House noted that the Congress has a responsibility to assist urban Indians in achieving a life of decency and self-sufficiency, and has acknowledged that it is in part because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities.

Unlike the Indian population on reservations, most but not all urban Indians are members of federally recognized tribes. Yet they are all Indian. They are all recognized as Indians by their community, their circumstances are principally the result of Federal Indian policies. They are deserving morally and legally of support from the Federal Government in achieving the highest possible health status.

Finally, I would like to address the status of the Oklahoma City clinic and the Tulsa clinic. Both clinics would like to be established as permanent programs. However, section 512 of S. 2526 would only make the Tulsa clinic a permanent program. We believe that it is in the interest of the Oklahoma City urban Indian client population that the Oklahoma City clinic also be established as a permanent program.

The National Council of Urban Indian Health thanks this committee for its support for urban Indians. We also thank the committee for this opportunity to provide testimony on the reauthorization of the Indian Health Care Improvement Act.

[Prepared statement of Ms. Namias appears in appendix.]

The CHAIRMAN. Thank you for speaking up for urban Indians. Out of the approximately $2.3 billion IHS budget, about $27 million goes to urban Indians, and yet half the Indians in America live in urban areas. And I think most of us are aware that they're pretty under-served. So thanks for your comment.

Let me also apologize before I go any further to Melissa. Now I know why you're so knowledgeable about health care, because you helped formulate some of the language that's in this bill, and you were here on a fellowship last year. And I'm sorry, it's part of age, I guess, I apologize for that. Thanks for coming back to testify.

And Virginia, Ms. Hill, I had on my chart for people who are testifying a Denis Turner. Is there a connection? Are you speaking in his place?

Ms. HILL. Yes; I am.

The CHAIRMAN. Okay, that will be fine. Why don't you go ahead.

STATEMENT OF VIRGINIA HILL, SOUTHERN INDIAN HEALTH COUNCIL, INC.

Ms. HILL. He was unable to attend today, and I'm here with Ralph Goff, who is the chairman of the Campo Band of Kumei and also the president of the Southern California Tribal Chairmen's Association.

As you are aware, there are two Indian provisions in TANF, the first, equitable access to services that the Governor had to assure to, and the second being direct funding to tribes so they could run their own TANF programs. Currently, there are 21 tribal TANF programs and 20 pending, including the Torres Martinez in Southern California.

As you are aware, one of the major problems to providing any service in Indian Country is transportation. Tribal members must fill out one application for cash assistance on the reservation and then seek transportation to go to a county welfare office to apply for Medicaid and food stamps. What we're proposing is a one stop application by providing all welfare related services on the reservation.

It's just a short, a very short amendment that we're requesting. And the language is, Indian tribes that administer a tribal TANF program are authorized to determine eligibility for the Federal Medicaid program. We have support, there is a resolution that was passed by NCAI in 1998 in support of this effort, and also support letters from the Cherokee Nation, the Osage Nation, tribal chairmen and several others that were sent to Paul Moorehead's office.

Thank you very much.

[Prepared statement of Ms. Hill on behalf of Ralph Goff and Denis Turner appears in appendix.]

Senator INOUYE [assuming Chair]. I would like to ask a few questions if I may. I would like to preface this by indicating that I am not a mathematician. But according to the numbers and statistics provided this committee, there are 556 federally recognized tribes. That is correct, is it not?

And according to the report, 146 of these tribes receive health care services from the Indian Health Service, is that correct?

Mr. TRUJILLO. Of the 558 federally-recognized tribes, over one-half are presently contracting or compacting tribes. Those other tribes are handled through the Health Service.

Senator INOUYE. According to the numbers that we have, 431 tribes are self-governance or compact tribes, is that correct?

Mr. TRUJILLO. That's pretty close to the number. It's over one-half the federally-recognized tribes are right now self-governance and contracting tribes.

Senator INOUYE. One-half?

Mr. TRUJILLO. Over one-half at the present time.

Senator INOUYE. So the numbers that we have are not correct?

Mr. TRUJILLO. I'll have to make sure that those numbers are correct. Right now we're dealing with about 558 federally-recognized tribes. Over one-half of those tribes are now compacting or contracting. As you recognized, the Alaska tribes and native villages are also inclusive of that.

Senator INOUYE. Well, I will give the full numbers. According to the numbers, there are 556 federally-recognized tribes, 146 are served by IHS and they receive 58 percent of the budget; 431 are self-governance tribes, and they receive 42 percent of the budget; 431 receiving 42, 146 receiving 58.

And about 48 percent of the total population of American Indian-Alaska Natives reside in urban areas, about 1 million, for their health services we have set aside $27.8 million. Is that correct?

Mr. TRUJILLO. In regards to the funding that tribes get and also that those urban programs, there are approximately 34 urban programs across the United Sates, it is through title V. The majority of Indian Health Service funding does go to tribes and self-governance compacting, and to those tribes who wish to remain within the delivery system of Indian Health Service.

Senator INOUYE. I hope you will get together with the staff to clarify this. Because according to the written numbers we have here before me, that's what it says, and it just doesn't make sense that you would spend nearly 60 percent of the budget for 146 tribes and 40 percent of the moneys for 431 tribes. So will you have this clarified?

Mr. TRUJILLO. Yes; we will. But you have to remember that our funding is not per capita. It's based upon the various previous budget allocation. We also fund a number of facilities, the majority of Indian Health Service facilities, of course, are off, are not in the urban centers, but rather in reservations or remote sites such as Alaska or other places like that.

Senator INOUYE. I would like to get those numbers, also, because I would like to see if we are appropriately funding the self-governance tribes. It would appear from the numbers that have been provided to the committee that they are not appropriately funded.

Now, I do not want to come to that conclusion, but that is what the numbers tell me here.

Mr. TRUJILLO. Is this in regard to the self-governance tribes?

Senator INOUYE. According to—I will read this here. Self-governance tribes receive 42 percent of the IHS budget, which is $2.39 billion. And they manage 13 hospitals, 160 health centers, 3 school health centers and 236 health stations and native village clinics. Is that wrong?

Mr. TRUJILLO. That's approximately right. The majority of the self-governance tribes are also quite small in regards to numbers and also locations.

Senator INOUYE. And then it says here, and I am quoting, "direct health care services", that is what you provide, account for 58 percent of the IHS budget, and 36 hospitals, 58 health centers, 4 school health centers and 44 health stations. Fifty-eight percent for 146 tribes, 42 percent for 431 tribes.

Mr. TRUJILLO. Correct. Fairly correct. Within those direct service tribes, you also have the Navajo Nation, which is the largest tribe in the United States.

Senator INOUYE. So if you work it out, I want to get a better understanding. And also, the population figures. Because if these numbers are placed here without explanation, one would get the impression that a lot of money is being spent for bureaucracy, and it is not benefiting Indian Country.

Mr. TRUJILLO. We will give you appropriate numbers. In fact, the Indian Health Service has one of the lowest amount of administrative overhead in regards to the program base. The majority of funding does go to tribes, direct services, as well as urban programs. So your impression, or others' impression, could be a mistake in that regard.

Senator INOUYE. And the measure before us is a bill that was made by Indian Country, is that not correct? Who represents Indian Country here?

Ms. MCNIEL. I do.

Senator INOUYE. Are you satisfied with this measure?

Ms. MCNIEL. Well, as I stated in my testimony, the Cherokee Nation does support this bill strongly. We do have several recommendations that we submitted in our testimony.

Senator INOUYE. And Indian Country has had appropriate input in the drafting of this measure?

Ms. MCNIEL. As you know, there was a National Steering Committee that was put together that had appointed tribal representatives from the 12 areas of Indian Health Service. And it went through, they held several regional consultation conferences throughout the country where people could come and offer input.

So yes, it is a bill that has gone through tribal consultation, lots of input from the tribes.

However, nothing, you know, takes the place of a tribe having their sovereignty to have input on things. So with that said, yes, the bill has had lots of tribal input.

Senator INOUYE. Are you satisfied that the self-governance tribes are content with the funding provided? Are they happy with the funding?

Ms. MCNIEL. Well, of course, the funding for Indian Health care in itself is terrible. I don't know what other word to use. It's so under-funded. And I'd like to refer back to the study that I referred to in my comments on the level of need funded study, which was a study that was commissioned by Congress to look at the inequalities in Indian Health Care funding, not only in the Indian health care system, but also throughout the Federal system.

Indian health care funding, compared to the Federal system, a Federal employee receives health benefits that averages, I think it's about $2,800 per person. And Indian Health Service average is about $1,450 per person. And I just want to add, since I'm from Oklahoma, that Oklahoma is the lowest funded. And we're at $856 per person.

Senator INOUYE. I ask the question because I want it for the record. I am well aware of the discrepancies and the unfairness and the inequity. But we need it for the record here.

I know for example that the doctors in the Public Health Service are paid less than Defense Department doctors or Veterans Administration doctors. And their work is just as valuable, if not more valuable, than many of those other physicians. So the inequity runs right through the whole system.

Ms. MCNIEL. Yes, sir.

Senator INOUYE. Are you satisfied that the services provided by self-governance tribes are just as good as those provided directly by IHS?

Ms. MCNIEL. Oh, absolutely. I personally think that self-governance tribes that deliver their own health care system provide better health care. And the reason I say that is that people tend to generalize tribes as Indian people. But every tribe is unique. And the health care needs of individual tribes are also unique.

And a tribe that delivers their own health care system can tailor and redesign their health care system to meet those unique needs of those individual tribal members.

Senator INOUYE. In general, do the professionals, such as physicians, in the self-governance program, receive pay equal to that of the public health officers?

Ms. MCNIEL. I'm not sure I can answer that in general. I think that, I want to say yes. And the reason I want to say that is because the quality of the self-governance, and I'm speaking on behalf of Cherokee Nation, because we are self-governance and deliver our own health care, that the quality of our providers is top, is rated at the top.

So I guess in general I would want to say yes, but I don't know that for a fact. I've not done an analysis of that.

Senator INOUYE. I have several questions, including those prepared by the chairman of the committee, which I would like to submit to all of you for your consideration and response.

So with that, on behalf of the chairman, I thank all of you. And with that, the hearing is adjourned.

[Whereupon, at 2:56 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Good afternoon. The committee will come to order. Today's hearing marks the third in a series of hearings considering S. 2526, the Reauthorization of the Indian Health Care Improvement Act of 1976 [act], legislation I introduced along with Senator Inouye earlier this year.

The 1976 act forms the legal cornerstone for the provision of health services to Indian people, and its importance cannot be overstated.

American Indians and Alaskan Natives continue to suffer the worst health status of any racial or ethnic group in America. As I have stated before, Native people suffer diabetes at a rate that is three times that of the general population and alcoholism and cancer at rates that are six times greater than the general population. The statistics are appalling, yet it must be recognized that the overall status of Indian health has vastly improved over the last 25 years, an improvement that can be largely attributed to the efforts of Congress, the tribes and the Indian Health Service operating together and pursuant to authorizations granted under this act.

First passed in 1976, the Indian Health Care Improvement Act has been reauthorized four times. The overall purpose of the act is twofold: No. 1, to address and minimize the health disparities among Native people in a coherent manner, and No. 2, to encourage and maximize the number of Native people involved and participating in health care delivery in Native communities.

Additionally, this reauthorization seeks to reaffirm key principles with the passage of this legislation. First, we recognize that federally provided health services for Native people are consistent with the unique legal and political Federal-tribal relationship. Second, we reiterate that a key Federal goal of the United States is to provide the quality and quantity of health resources necessary to elevate the health status of American Indian and Alaskan Native people to the level enjoyed by most Americans.

Finally, and consistent with long-standing principles of Indian self determination and self governance, we continue to stress the importance of American Indian and Alaskan Native participation, to the maximum extent possible, in the planning, management, and implementation of health services.

S. 2526 is the product of hundreds of hours of hard work and is the culmination of tireless efforts of Indian tribes, urban health centers and the Administration to develop a draft bill that provides flexibility in the operation of Indian Health programs yet ensures their effectiveness.

Our hearing today will focus on three important aspects of the reauthorization legislation: No. 1, title IV, which deals with third party billing, and serves as an important source of cash-flow for Indian Health Service operations and allows them stretch the Federal dollar further; No. 2, title V, which authorizes the provision of health services to urban Indians through a grant program to urban Indian organizations; and No. 3, title VI, which deals with the organizational structure of the Indian Health Service.

Important changes have been made to each of the titles of the bill we will discuss today. For instance, changes have been made to title IV which makes permanent and expands a demonstration program that allows tribes to collect reimbursements for Medicare and Medicaid directly from Federal sources, rather than continuing the current convoluted process which requires a tribe to send their billing through the IHS which, in turn, seeks reimbursement on the tribe's behalf.

Changes to title V would streamline the processes for grant applications and contracting, and expands authorizations for the provision of services by urban programs, including eligibility for diabetes grants and the operation of the community health representative program.

Title VI provides that the Office of the Director of the Indian Health Service shall be elevated to the position of Assistant Secretary for Indian Health within the Department of Health and Human Services, a change supported by this Committee, the tribes, as well as the Department. Title VI also provides for the establishment of an automated management information system.

These changes are far reaching in their implications and I am looking forward to hearing from our witnesses today.

As we all know, there are barely 25 days remaining in the 106th Congress and there is much work for this committee to do. It is my intention that the committee report this legislation in this Congress and lay the groundwork for its continued consideration in the 107th Congress. The comments we hear today will do much to further the development of S. 2526.

PREPARED STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

Mr. Chairman, I want to thank you for convening this hearing on legislation to reauthorize the Indian Health Care Improvement Act [IHCIA]. As has been documented at the earlier hearings on this subject, there is a health care crisis occurring in Indian country. Native Americans are still 5.3 times more likely to die of tuberculosis, 4.4 times more likely to die of chronic liver disease and cirrhosis, 2.5 times more likely to die of diabetes, 3 times more likely to die in an accident, and nearly twice as likely to commit suicide.

It is vitally important that Congress address these problems as part of the reauthorization of the IHCIA, which is scheduled to expire on September 30 of this year. The IHCIA is the major Federal law governing the delivery of health care to Native Americans, and it authorizes funding for health service delivery, programs to help ensure an adequate supply of Indian health professionals, health care facility construction, and health services for urban Indians, among other things.

This is the third in a series of four hearings the committee has planned on reauthorization of the IHCIA. I'm pleased, Mr. Chairman, that you have agreed to let me chair the fourth hearing on this important subject, along with Senator Conrad, next Friday, August 4 in Bismarck, ND. This field hearing will focus on titles VII and VIII of the reauthorization legislation, as well as Native Americans' access to prescription drugs. I will submit a longer statement for the record at next week's hearing.

Thank you, again, Chairman Campbell for your work and leadership on this issue.

PREPARED STATEMENT OF CHARLIE CURTIS, PRESIDENT, NANA REGIONAL CORPORATION, INC.

My name is Charlie Curtis, and I am the president of NANA Regional Corporation, Inc., one of the 12 Alaska Native Regional Corporations created pursuant to the Alaska Native Claims Settlement Act for the natives of northwest Alaska. NANA has over 11,000 Inupiat shareholders.

One of NANA's goals as a native corporation is to provide job opportunities for its shareholders. NANA employs over 1,500 employees, many of whom are shareholders. Employees in full time, non-temporary positions receive benefits, including health insurance. NANA is self insured for health care benefits.

NANA has seen a significant increase in the cost of its health care benefits in the past several years as a result of rebilling by Indian and Native entities running health care facilities in Alaska under-funding agreements pursuant to the Indian Self-Determination and Education Assistance Act.

I have reviewed a copy of the testimony of Mr. Jacob Adams, president of Arctic Slope Regional Corporation, on S. 2526, which I understand has previously been provided to you. NANA agrees with the comments made by Mr. Adams. Like ASRC, NANA, and not the Federal Government, is being asked to pay for the health care

services of its Alaska Native shareholder employees. This result is not compatible with Congress' intent to provide, at the Federal Government's expense, health care services for Alaska Natives.

Accordingly, NANA supports the adoption of section 406(g) of S. 2526.

Thank you for the opportunity to comment.

PREPARED STATEMENT OF GREGORY E. PYLE, CHIEF, CHOCTAW NATION OF OKLAHOMA

Chairman Campbell, members of the committee, ladies and gentlemen: Thank you for the opportunity afforded the Choctaw Nation of Oklahoma to provide testimony before such a distinguished body on this vital piece of legislation.

The Choctaw Nation is located in the extreme southeast comer of Oklahoma. Our historical boundaries encompass 10½ counties. Our tribal enrollment exceeds 140,000 Choctaws and they are scattered throughout the United States and across international boundaries. Our health service population is over 40,000, treating primarily Choctaw, but our open door policy assures that we will see many of representatives of the 557 federally recognized tribes. Many of our people are poor, living well below the national standard. Three of the counties within the Choctaw Nation have the lowest income rates in Oklahoma. Quality health care provided by the Choctaw Nation is a necessity for the people in our service area. not a luxury. The majority of people that we serve have no other choice. We are their only access to health care.

We take much pride in the direction the Choctaw Nation is moving. On July 14, 1999, we opened a new hospital in Talihina, OK. We built this $28 million, 144,000 square foot, facility with Choctaw Nation dollars, not Federal dollars. We were trying to provide health care to our population in an old TB sanitarium, built in the 1930's. This was unacceptable to us. As you can see, the delivery of quality health care to our people is our first priority.

With this in mind, allow me to make comments on the proposed legislation. In the interests of expediting the committee's considerations, and making our comments as helpful as possible, I will be brief.

Title 1: Indian Health, Human Resources and Development.

Any health care system cannot function without trained and qualified health care providers. Title I attempts to bring that qualification responsibility to the local level, by increasing requirements for qualified personnel. This is the goal, and the requirements are good, if you live in an area that is attractive to professional people. However, attracting service providers is a large issue with us. While it is beautiful and scenic in the Choctaw Nation, it is a great distance to large cities and all those things that cities can provide. People at the top level of their professions gravitate toward the cities, with their social, economic and education advantages. Priorities must be established to assist locations, such as ours, who have difficulties in recruiting. Enhanced scholarship programs must be provided with service fulfillments increased for service in Health Professional Shortage Areas. This is not a new concept, but it seems to have fallen by the wayside. We hope the committee will consider it for this title.

Title II: Health Service.

The Choctaw Nation of Oklahoma was one of the first tribes to contract for all the Indian Health Services provided to its citizens (1985). In 1994, we entered into a title III, self-governance agreement and have been aggressively carrying out our own programs. We know that the Indian Health Service budget is woefully inadequate. We urge the Congress and the Administration to pay heed to our requests for increased funding in fiscal years 2001, 2002 and subsequent years. We particularly want to draw the committee's attention, again, to the disparity in the funding for Indian Health Services, when viewed from two perspectives: First, compared to the general population, and second, when looked at among IHS service areas. A recent study, conducted under the auspices of IHS and called the level of need funding study, estimated that IHS funding was less than 12 percent of the funding spent on a comparable group of non-Indian study subjects [subjects were substantially supported in health care by the Federal Government]. This severe underfunding means a lack of services for all Indian trust-responsibility recipients of the Federal Government. In addition, the level of need study found that some IHS service areas were receiving 2½ times the amount of funding other areas were receiving. Due to historical and other factors, the Oklahoma area is the lowest in per capita funding among all IHS service areas. We ask specifically that Congress urge the director, Indian Health Service, that any new funding, above and beyond the level in the cur-

rent appropriations cycle, be distributed under the methodology presented by the level of need funded workgroup.

Diabetes is an illness connected to Native American populations in a disportionate percentage. Diabetes is killing and disabling our Indian people at alarmingly increasing rates. Early onset of type II diabetes, for instance, is now showing up in children, a situation which did not exist just 20 years ago. Tribal programs must receive increased funding for diabetes. Funding must not be restricted and placed in a contracting status, such as in the 150 million dollars diabetes demonstration project. We are competent to spend the money appropriately. The level of funding for this disease should be increased, and the number of different services provided should be increased. In Oklahoma, for instance, the Choctaw Nation, in conjunction with the University of Oklahoma, is seeking funding for the establishment of a Registry, to aid in identification and early treatment of this condition. This registry could be replicated and expanded throughout the State. Early detection, and diabetes prevention programs for those determined to be at risk, are key to getting a handle on this silent killer of Native Americans.

Title III: Health Facilities.

The Choctaw Nation took the responsibility, and built, a new hospital. We were on the Indian Health Service facilities list. However, it would have been years before we would have been funded. Also, we were able to build our hospital for almost 20 million dollars less than the Indian Health Service had estimated. The Choctaw Nation has also built an ambulatory clinic at Pouteau, OK through the joint venture program with Indian Health Service. We all acknowledge that there will never be enough money appropriated to keep our hospital and clinics up to the profession's standards. We must be innovative, using programs such as joint venture. We ask Congress to work closely with tribes and the Indian Health Service in these efforts. We offer ourselves as examples of what can be done, and we assure the committee we will work with any other tribes who seek to benefit from our experiences.

Title IV: Access

Tribal programs which have used their own initiative to move forward into contracting and compacting have set the standard for Indian Health Service in billing and collecting for third party reimbursements. In the period of little or no budget increases, this is the life-blood of our health programs. The Choctaw Nation of Oklahoma is one of four tribal programs in a demonstration program that allows for direct billing from third parties. We ask that the Choctaw Nation of Oklahoma be allowed to retain that status. We also, would support opening participation in this demonstration project to any tribal program wishing to participate. For these reasons, we thank the committee for its actions on S. 406, a bill to accomplish these tasks, and promise to work for its passage in the House.

Title V: Health Services for Urban Indians.

The Choctaw Nation recognizes that Indian people do move to larger cities seeking employment and education. Section 512 has become a major divisive issue for tribes and urban programs in Oklahoma. The Oklahoma City Urban Center and the Tulsa Urban program have been in demonstration status for 7 years. Section 512 would make these two programs permanent and would place them outside the scope of Indian self-determination. This proposed action would set a precedent that is contrary to self-determination and Self-Governance for Indian tribes and their citizens, as well as with the intent of all other legislation concerning services for Indian people. Services and resources to support those services are tied to federally recognized tribes that have a reservation land base or a previously defined land base, which resulted from individual treaties between tribes and the United States.

The demonstration authorization of funding for Federal Urban Indian Health Services resources, outside the responsibility of tribes, establishes the precedent that any group of Indian citizens or and individual Indian can have Congress set them up in business independently without honoring the Federal/tribal government to government relationship. While the two demonstration projects in Oklahoma City and Tulsa have addressed health care needs, they are clearly absent of any input and/or participation of the tribal governments, which are authorized to represent the Indian citizens to whom they are providing services. Before any final action is taken on this section, we suggest field hearings in Oklahoma to address this issue.

Title VI: Organizational Improvements.

The Choctaw Nation supports the elevation of the Director of Indian Health Service to the level of Assistant Secretary.

Title VII: Behavioral Health.

The Choctaw Nation supports additional funds to assist our patients in the mental health and substance abuse arena. However, we do not support the regional treatment center concept for existing or expanded programs. Historically, in-patient treatment without intense participation by the families or those significant to the

patients have failed. Regional programs located 3 to 4 hours from patient homes are not workable, or accessible to other working family members. Dollars provided for these regional programs should be made available to local programs that are underfunded. These dollars must remain at the local level.

Conclusion.

Indian Health Service programs carry the major load for assuring a minimum quality of life for your constituents, and my constituents. The Choctaw Nation of Oklahoma is among the leaders in taking the responsibility for these programs and their administration onto tribal shoulders. The health care of its people is the first priority of the Choctaw Nation. I appreciate the opportunity to share my statements with the committee. Positive and ongoing dialog will make the relationship between the U.S. Government and our tribal government stronger.

Thank you

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

JOHN J. CALLAHAN

ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET

BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

HEARING

ON

S. 2526

THE INDIAN HEALTH CARE IMPROVEMENT ACT
REAUTHORIZATION BILL

July 26, 2000

STATEMENT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON
S. 2526 – TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT
TO REVISE AND EXTEND SUCH ACT

July 26, 2000

Mr. Chairman and Members of the Committee:

Good afternoon, I am pleased to testify today on behalf of the Secretary of the Department of Health and Human Services on this historic legislation, S.2526, the Indian Health Care Improvement Act Reauthorization of 2000. Today, I am accompanied by Dr. Michael Trujillo, Director of the Indian Health Service (HIS), Mr. Michel Lincoln, Deputy Director, Mr. Gary Hartz, Acting Director of the Office of Public Health, and Dr. Craig Vanderwagen, Director, Division of Clinical and Preventive Services, Office of Public Health.

Since Dr. Trujillo last testified before this Committee, the Department has continued to review and analyze this complex and expansive proposal as reflected in S. 2526. The Indian Health Care Improvement Act (IHCIA) was originally enacted in 1976 to provide additional guidance and authority for the programs of the federal government that deliver health services to American Indian/Alaska Natives. The reauthorization of this cornerstone authority provides an opportunity for all of us to revisit the original intent of this legislation, and examine the Act in light of the many changes that have occurred in the health care environment during the past 24 years.

The IHS has the responsibility for the delivery of health services to Federally recognized American Indian and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (ITU)-operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level, in partnership with the population served. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. And, the Department's responsibility is to uphold the Federal government's obligation to promote healthy AI/AN people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

The Tribal Steering Committee Draft bill, upon which S. 2526 was based, was submitted to Congress by tribes directly and does not necessarily represent the Administration's views on policies. The Tribal and urban Indian health care proposals now contained in this bill recommend the most sweeping changes in the history of the IHCIA. S. 2526 contains recommendations that require careful analysis to determine the full impact of the bill's many recommendations.

In drafting the bill, tribal and urban Indian representatives placed no parameters or limitations on changes that they might consider or recommend for the reauthorization of IHCIA. This bill includes new requirements for IHS by establishing new and expanded authorities, which will increase expectations and place additional pressures on IHS' ability to operate programs within

its limited appropriation. We have concerns that these expansions would detract from IHS' ability to carry out its mission of providing basic health care services to AI/ANs. Also, since many of the new provisions convert grants into programs available for tribal Self-Determination contracts and compacts, the associated Contract Support Costs could increase proportionately. The FY 2001 Budget included a historic $230 million increase for IHS. Even though this is the largest funding increase ever requested, IHS would not be able to implement these expanded authorities.

S. 2526 contains eight (8) titles that encompass most of the health related provisions in the existing IHCIA: Title I, Indian Health, Human Resources and Development; Title II, Health Services; Title III, Facilities; Title IV, Access to Health Services, Title V, Health Services for Urban Indians; Title VI, Organizational Improvements; Title VII, Behavioral Health Programs; and Title VIII, Miscellaneous. The Administration is in the process of reviewing the many new provisions proposed in the tribal draft legislation in the context of the President's Budget. We are not prepared today to provide the Committee with a formal position on this expansive legislation without completing a thorough review. We will share with you today our views to date on some of the provisions contained in S.2526.

Title I – Indian Health, Human Resources and Development

The purpose of this title is to ensure that Indian health programs have an adequate supply of trained professionals able to provide culturally appropriate care. In order to achieve this goal, Title I includes provisions for the education and training of health care professionals. Many

provisions in the existing statute are proposed to be amended to accommodate the rapid pace of change in the health fields in future years. We note that Sec. 105 – Indian Health Professions - combines two separate scholarship programs into one section. Under the existing statute, Sec. 104 contains the Indian Health Service Scholarship Program and Sec. 120 contains the Matching Grants program. These two programs are separate in their administration and we would recommend they remain separate in the reauthorization of this provision.

Title II: Health Services

A number of provisions in Title II of the bill will assist in our efforts to reduce unnecessary disease and injury and raise Indian health to the highest possible level. There are many health care priorities in Indian Country, but effective prevention and treatment of diabetes and its related complications must rank among the highest. Sec. 204 of the bill would institutionalize the progress we are making with the diabetes program funded under the Balanced Budget Act of 1997, by establishing an ongoing national program within the IHCIA. This would be comparable to the President's proposal to amend the diabetes program in the Balanced Budget Act to continue funding for this important program. Sec. 212 would update and expand our tuberculosis program to focus more broadly on all communicable and infectious diseases.

Section 224(a) clarifies that patients receiving contract health services (CHS) authorized by the Service will not be liable for payment of charges or costs associated with provision of those services. This protection, together with additional protections in Title IV, would provide greater peace of mind for Indian patients who worry about dunning letters and damage to their credit because of CHS provider attempts to recover payments from them as well as from the Service.

Title III: Facilities

Sec. 301(a)(2) provides for newly constructed or renovated facilities, whenever practicable, to meet the construction standards of any nationally recognized accrediting bodies, not just JCAHO. This provision recognizes the expanding number of accrediting bodies; however, the Secretary does not recognize all of them for the various provider types they accredit. Because it appears as though the intent is to assure that construction and renovation funds maximize the likelihood of the facility being able to collect Medicare and Medicaid payments, it may be more appropriate to revise this provision of the bill to reflect that intent.

S. 2526 greatly expands agency program reporting requirements. We have general concerns about the overall reporting burden placed on IHS because it could require the diversion of resources from other much needed programs, including patient care, facility maintenance and other critical areas of the IHS programs. In addition, of concern is the new provision in Sec. 301(c) that would require the Secretary to report annually on the needs for health care facilities construction, including the renovation and expansion needs of existing facilities. While the first year report to Congress does not require consultation with Tribes, IHS would need to develop a baseline description of existing facilities and determine the need based on existing programs, facility conditions, facility efficiency and other factors.

Section 303(b) eliminates applicability of Davis Bacon wage rates for construction of Indian Health Service facilities. The Administration has significant concerns about this provision. The Administration is firmly committed to maintaining the important worker protections provided by

the Davis-Bacon Act which applies to workers employed by contractors and subcontractors performing on Federal or Federally-assisted construction projects.

Sec. 310 provides new authority for joint ventures between IHS and Tribes as an alternative to the long wait on the IHS facilities construction priority list. This proposed authority could assist the IHS and Tribal health programs in meeting the construction needs of facilities, which average 30 years of age, and maintenance and repair of many of the facilities in Indian country. Before moving ahead on any new Joint Venture projects in the future, IHS will need to examine the following issues: a) find a way to integrate and prioritize joint ventures with the IHS Facilities Construction Priority Lists; b) ensure that long term costs associated with staffing and operations are consistent with IHS standards for providing health care facilities and services to Federally Recognized American Indians and Alaska Natives can be accommodated by future funding levels; and, c) assure the funding committed to Joint Venture projects addresses priority needs for health care facilities and the delivery of health care services with the highest relative need.

Title IV: Access to Health Services and Conforming Amendments to the Social Security Act

In many respects, the changes in Title IV are the most far-reaching changes in the bill, both for the IHCIA and for the Social Security Act. We currently do not have cost estimates for this bill. In addition, we have not thoroughly assessed every provision for administrative feasibility and consistency with the President's Budget. I will highlight some provisions in this title.

Many of the changes in Title IV and conforming amendments to the Social Security Act focus on provider payment issues. Previous amendments to the IHCIA and the Social Security Act allow I/T/Us to bill Medicare and Medicaid in certain, limited ways and were intended to provide access to additional funds to supplement, not replace the IHS appropriation. Since those earlier amendments, both the general health system and Indian health have changed dramatically.

It is important to remember that there are fundamental differences between public health programs like IHS and many other HHS health programs, and health insurance programs like Medicare and Medicaid. Public health programs generally have limited funds, but they have broad discretion on how those funds may be used. Exactly the opposite is the case with Medicare and Medicaid, which are health insurance programs that guarantee payment with unlimited Federal funds, but place their limits on both the type of benefits and the categories of individuals for which those funds can pay. It is not surprising that IHS and HCFA programs, starting with such basic differences, have developed some incompatibilities.

Title II, sec. 203 adds a number of detailed provisions for a new provider type called a Qualified Indian Health Program (QIHP), for I/T/Us that want to participate in Medicare and Medicaid. The QIHP provisions contain a number of exceptions to the usual coverage, payment, and other rules for those programs. While creation of an Indian-specific provider type could address problems Indian providers face, the proposed QIHP is extremely complex and would present a number of difficulties in its administration.

Similarly, sec. 423 sets out a series of managed care payment rules and exceptions which may have unintended adverse consequences. In a growing number of States, health is dominated by managed care. Exempting Indian health from such systems could leave Indian providers and their patients without access to the significant advantages of increased benefits and care coordination common to such managed care systems. A simpler and more effective approach needs to be developed to address these issues.

Some proposed solutions in the bill are broader than necessary to address the underlying problems. For example-we understand that some people have read the current Emergency Medical Treatment and Active Labor Act (EMTALA) to require that Indian clinics transport emergency patients to their parent hospital even when an appropriate transfer to a closer hospital is warranted. As HCFA stated in its recent regulation concerning provider-based status, HCFA does not actually read EMTALA this way. We believe the problem could be addressed by some targeted technical assistance to Indian facilities on their responsibilities under EMTALA. In any case, it is unnecessary and perhaps unwise to exempt Indian clinics from the very important EMTALA patient protections, as Title II, sec. 202(e) proposes.

We have concerns with several other provisions in Title IV, including the following issues.

100% Reimbursement to States

Several provisions of the bill would extend the 100% Federal matching rate to States for

additional Medicaid and SCHIP services to AI/ANs. This would increase Federal program and related administrative costs.

Requirement on Medicare to reimburse for all non facility-based services

This provision would require Medicare to reimburse for all non facility-based services (e.g., home health, community-based care, ambulance services, physicians, DME, lab) provided by IHS providers. Currently, the Medicare statute requires HCFA to reimburse IHS for facility-based services (e.g., hospitals and SNFs). This would add significant new costs to the Medicare program.

Improving Access of Indian Beneficiaries to Medicare, Medicaid, and SCHIP

Sec. 419 proposes to waive Medicaid and SCHIP premiums and Medicare, Medicaid, and SCHIP cost sharing. The Administration is on record supporting waiver of premiums and cost sharing for Indian beneficiaries in SCHIP. The Medicare late enrollment penalty is necessary for an insurance program like Medicare to avoid the negative economic consequences of "adverse selection" where individuals do not enroll or pay premiums until they are ill with costly health conditions. A statutory waiver of the Medicare late enrollment penalty, therefore, is undesirable and unnecessary given administrative actions, and provisions elsewhere in the bill, that will encourage low-income Indian elders and persons with disabilities to enroll in Medicaid, which will pay Medicare premiums for them.

Consultation

Many sections of S. 2526 have tribal consultation requirements. We are concerned that these added responsibilities would stretch our resources at the expense of other programmatic responsibilities. Tribal consultation has been an important priority for this Administration. In HHS, we appreciate the value of consultation and are increasingly involved with Tribes in this process. However, we have some concerns about the specific manner in which Section 414(a) of S. 2526 would require consultation to occur. This provision requires consultation, as defined in Executive Order 13084 of May 14, 1998, to be held with Indian Health Service, Tribes and Urban Indian Health Programs (I/T/U's) prior to HCFA adopting *any* policy or regulation. Similar language in section 514 requires all Health and Human Services agencies to consult with urban Indian organizations prior to taking any action, or approving any action of a state, that may affect urban Indians or urban Indian organizations. While we value meaningful consultation on matters relevant to tribes and ITU providers, we believe these sections of the bill could be improved by providing for a process that more specifically identifies regulations and policies relevant to Tribes, *I/T/U* providers and urban Indians. In addition, reference to a particular Executive Order may be impractical if it is superseded or rescinded. It may be more effective to use language in the current Department of Health and Human Services (HHS) consultation policy.

Negotiated Rule Making

HHS agencies have had first-hand experience with the positive contributions of negotiated rule making. Section 553 of 5 U.S.C. Negotiated Rule Making, lists factors to be considered in

determining whether or not to use the negotiated rule making procedure. These factors include: a limited number of identifiable interests that will be significantly affected by the rule as well as reasonable likelihood that a committee can be convened with a balanced representation of persons who are willing to negotiate in good faith to reach agreement by consensus on the proposed rule within a fixed period of time. Where such factors are present, negotiated rule making can be very helpful in structuring a process through which relevant stakeholders participate constructively in developing a recommended rule. However, S. 2526 would require negotiated rule making in many of its provisions. For example, Section 414 (b) would require HCFA to use the negotiated rule making for the development of all regulations to implement provisions contained in Title IV that would amend the Social Security Act, and section 802 would require the Secretary to use negotiated rule making for all regulations to implement this Act.

Negotiated rule making is very resource intensive for both Federal and non-Federal participants, and may not be the most effective way to obtain necessary I/T/U provider input in the development IHCIA rules and regulations. We would recommend instead utilizing the consultation to identify areas in the reauthorization legislation where the negotiated rule making process would be appropriate for the development of regulations.

Additionally, Section 802(b) of the bill limits membership on negotiated rule making committees to Federal and Tribal representatives. For committees to implement provisions related to Medicare, Medicaid and State Children's Health Insurance Program (SCHIP), it would be

important to include representatives of State agencies charged with implementing these programs, as well as other key provider and beneficiary interests. This would increase opportunities for Tribal and other Indian representatives to build consensus and support in the development of final rules to implement the bill's various provisions.

Other General Comments

In a number of sections in the bill, for example Section 103(a), the word "grant" is stricken and replaced by "make funds available." Deleting the word "grant raises" the concern that the Department's regulations at 45 CFR might not apply to any funding agreements under this bill. We suggest using the term "grant" where appropriate throughout the bill.

There are also several sections, for example section 516(a), where the Secretary is directed to pay for services that are not presently provided. In the absence of additional appropriations, complying with these provisions would require funding reductions for existing services that are no less necessary. We suggest that any requirement for the provision of new services be subject to the availability of appropriations.

We have not had an opportunity to field cross-agency concerns over many exemptions for tribes, tribal organizations, and urban organizations on broader long-standing Federal policies, including the Davis-Bacon Act, the Buy American Act, Section 117 of the Internal Revenue Code of 1986, the Federal Reports Elimination Act of 1998, and the Anti-Deficiency Act.

Title V: Health Services for Urban Indians

Title V authorizes the IHS to assist in meeting the health care needs of American Indians and Alaska Natives living in urban areas. Currently, urban Indian health programs serve approximately 149,000 urban Indians in 34 cities through the country. We estimate that over 350,000 urban Indians are eligible for services. With a few exceptions, funding authority for urban Indian health is specifically limited to Title IV and Title V. All other references to urban Indian health found in the other titles of the bill address areas such as consultation, rule making planning or reporting only.

S. 2526 would streamline the process for contracting and making grants to urban Indian organizations. While we support a streamlined process for contracting and grant making, we do have concerns with the elimination of certain criteria in the existing statute in S. 2526. In the existing IHCIA, Sec. 503 of Title V requires that the urban organization successfully undertake certain activities as a condition to entering into a contract with IHS for the provision of health care and referral services for urban Indians residing in the particular urban center. The elimination of these criteria would be appropriate for on-going urban Indian contractors, but for new contractors, it would be important to retain those requirements as conditions for awarding a contract or grant.

Title V also contains new authority for the establishment of an Urban Indian Health Care Facility Revolving Loan Fund to provide guaranteed loans to urban Indian health contractors and grant recipients for construction, renovation, expansion, or purchase of health care facilities. In

addition, Title V authorizes the extension of Federal Tort Claims Act coverage for urban Indian health programs. These new provisions could assist urban Indian health programs, however, they would require additional resources and we would need to assess how these new provisions fit into the Administration's priorities for Indian health.

Title VI: Organizational Improvements

Sec. 601(a)(2) provides for the elevation of the Director of the IHS to Assistant Secretary for Indian Health. The Administration has presented testimony before this committee in support of S. 299, the stand-alone bill that contains the identical provisions of Sec. 601. We believe this provision would provide a stronger coordination and advocacy role in budget and policy matter related to Indian health.

In addition, Sec. 602 (d) would authorize the Secretary, acting through the Assistant Secretary for Indian Health to enter into contracts, agreements, and joint ventures with other Federal agencies, States, and private and nonprofit organizations, for the purpose of enhancing information technology in Indian health programs and facilities. The Administration promotes the partnership and collaboration with our sister Federal agencies in a variety of areas related to Indian health in order to maximize our resources and involvement with other Federal programs in the provision of health related services to AI/ANs.

Title VII: Behavioral Health Programs

Title VII includes many sections that were transferred from Title II, Health Services, in the

existing IHCIA. This title includes major revisions, specifically to integrate Alcohol and Substance Abuse provisions with Mental Health and Social Service authorities. Where appropriate, the term tribes, tribal organizations and Indian organizations are referenced in addition to IHS.

A broad range of behavioral health services is described under "continuum of care." Several related sections were moved from Title VIII in the existing IHCIA, including the section related to Fetal Alcohol Syndrome and Child Sexual Abuse. Demonstration programs were eliminated and replaced with language authorizing programs for Indian tribes and tribal organizations. A new section would authorize the establishment of at least one inpatient psychiatric treatment facility per IHS Area. These new centers would be funded on a similar basis as the Regional Youth Treatment Centers authorized in the existing IHCIA. We are concerned about the feasibility of establishing at least one inpatient psychiatric treatment facility per Area. The cost could be prohibitive and there could be difficulties in recruiting and retaining specialized staff, as well as the complexities of starting a new provider type.

Title VIII: Miscellaneous

Section 813 would deem tribal contractors and compactors as ordering agents of the Indian Health Service. We recommend that this language be revised to be consistent with the language in H.R. 1167 that authorizes tribal access to Federal sources of supply only for the purposes of carrying out an agreement under the Indian Self-Determination and Education Act.

This title establishes a National Bi-Partisan Commission on Indian Health Care Entitlement. This commission would be comprised of members of Congress, Tribal leaders, and Urban Indian health leaders to study the desirability and feasibility of making Indian health an entitlement. While many Tribal leaders and Indian people believe that the provision of health care to them should be a legal entitlement, there are many questions regarding the ramifications, including the costs, of such an entitlement.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to discuss the reauthorization of the Indian Health Care Improvement Act. We will continue to analyze the implications of this expansive legislation and will be happy to work with the committee and the Indian Health Care National Tribal Steering Committee to address the Administration's concerns. As we move into the new millennium, we must acknowledge and fulfill the long overdue obligation to advance the health status of Indian people to the highest possible level. We will be happy to answer any questions that you may have.

TESTIMONY OF MELISSA MCNIEL
EXECUTIVE OFFICER, OFFICE OF PRINCIPAL CHIEF
CHEROKEE NATION
BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON S. 2526
A BILL TO REAUTHORIZE THE
INDIAN HEALTH CARE IMPROVEMENT ACT
July 26, 2000

Good afternoon Mr. Chairman and Members of the Committee, my name is Melissa McNiel, and I am the Executive Officer in the Office of the Principal Chief for the Cherokee Nation. I appear here at the request of Principal Chief Chad Smith to deliver the Cherokee Nation's strong support for S. 2526, the Indian Health Care Improvement Act Reauthorization of 2000. With me are Cherokee Councilwoman Stephanie Wickliffe and Dr. Mim Dixon, Executive Director, Health Services for the Nation.

The Cherokee Nation represents over 213,000 tribal citizens, nearly half of whom live within our 7,000 square mile jurisdictional area. The Cherokee Nation has approximately 1,800 tribal employees (making it one of the largest employers in Northeast Oklahoma), about one-third of whom work in the Nation's health services division.

The Cherokee Nation was one of the first tribes in the United States to execute a self-determination contract under the original 1975 Indian Self-Determination Act and was also the very first tribe to execute a self-governance agreement under Title III of that Act. Since 1994 all of our self-determination programs have been administered under self-governance compacts with the Department of Health and Human Services (DHHS) and the Department of the Interior (DOI).

Under our self-governance compact with DHHS the Cherokee Nation operates six rural outpatient clinics with very limited resources. The Cherokee Nation also operates the inpatient and outpatient contract health services associated with Indian Health Service's (IHS) W.W. Hastings Hospital in Tahlequah, Oklahoma.

The Cherokee Nation applauds this Committee's effort to ensure that the many positive benefits of the Indian Self-Determination Act apply with full force to Indian health care. The President, Secretary Shalala, and Congress, including this Committee, have all recognized that the

federal policy of tribal self-determination and self-governance has been the most successful federal Indian policy in our Nation's history. Congress has an important role to play in protecting and preserving these policies. You have once again done this through the introduction of this legislation.

Twenty-five years ago the Cherokee Nation began the process of self-determination contracting to operate IHS programs to streamline, redesign and enhance federal services for our people. As a result of our vision and our determination, the Cherokee Nation has succeeded in substantially reducing the federal bureaucracy, enhancing local control and making vast improvements in the efficiency of these programs for the benefit of our people.

As you, Senator Campbell, stated in your Introduction Statement for this bill, it "re-affirms the core principles that were part of the 1976 legislation: (1) that federal health services are consistent with the unique federal-tribal relationship; (2) that a goal of the U.S. is to provide the quantity and quality of services to raise the health status of Indians, and (3) that Indian participation in the planning and management of health services should be maximized."

We strongly support the provisions of S. 2526 to continue this self-determination effort. This reauthorization not only strengthens the tribes, but also enables the IHS and other health agencies to better serve tribal members. These federal agencies will become stronger, not weaker, once they stop resisting the natural desire of Indian tribes to govern themselves and start figuring out ways to become true partners, strong advocates and helpful resources for all tribes.

The reauthorization of this Act was conducted under the Tribal Consultation Policy. Indian Health Service convened a Roundtable in June 1998 to begin the discussion of the reauthorization and to give guidance to the consultation process, which included all stakeholders, IHS/Tribes/Urban (IHS).

Coordinators from the 12 IHS Areas formed workgroups of stakeholders and National Indian Health Board representatives. These meetings were to inform the stakeholders about the reauthorization process, and provide opportunities to discuss and reach consensus on recommendations for the Act.

Four regional consultation meetings were held to provide further opportunities for the stakeholders to provide input, share recommendations from the Areas, and build consensus among

participants for a unified position. The final report entitled "Speaking with One Voice" identified areas of consensus and differences.

The IHS Director convened a National Steering Committee (NSC) to be responsible for the final drafting of the report on the IHCIA recommendations. The NSC is composed of one elected and one alternate tribal representative from each of the 12 Areas, a representative from the NIHB, National Council of Urban Indian Health (NCUIH), and the Self-Governance Advisory Committee. During the course of the 4 meetings, this group's tribal responsibility evolved from compiling a final report of recommendations to the drafting of the actual IHCIA reauthorization bill language.

A National Forum, which was co-sponsored by this Committee, provided time for tribal leaders, urban health representatives, national organizations, related federal agencies and other friends of Indian health, to provide feedback on the draft of the IHCIA reauthorization bill.

With this bill being the product of what we consider to be true tribal consultation, we believe that it will improve the current health care delivery system in many positive ways, including local control and flexibility, and responsiveness to the health needs of Indian people.

We are very happy that this bill sets the tone by focusing on the health status objectives for Indians and by stating that they should be at least as good as the U.S. population as a whole.

Since today's hearing is to focus on Title IV, V, and VI, let me now speak briefly about each:

Title IV - Access to Health Services

Title IV provides some very constructive ways to assure that the American Indian and Alaska Native people benefit from Medicaid, Medicare, Child Health Insurance and other federally-funded health care programs in addition to the IHS delivery system. With a history of federal funding that is significantly below the needs of the American Indian populations, it is important the Indian health care delivery system maximize funding from these sources.

If health care for American Indians was treated as an entitlement, we would not have to talk about supplemental sources of funding. If Indian health care was treated as an entitlement, the federal funding would automatically be adjusted to accommodate population increases and inflation. However, this has not happened. Each year the inflation-adjusted per capita funding

for Indian health declines. So, we must have alternative sources of revenues. Even with Medicaid and Medicare and Child Health Insurance, the funding for personal medical services in the Indian health system is 40 percent less than the health care funding for federal employees. So the provisions in Title IV are essential to preventing the further deterioration of the Indian health care system.

As a whole, we support the provisions in this section; however, we also offer some suggestions for strengthening the language and concepts in Title IV.

Sec. 409. IHS, Department of Veteran's Affairs, and Other Federal Agency Health Facilities and Services Sharing

(c) Agreements for Parity in Services. We are pleased that Congress is considering parity in services in this section. However, there are other issues of parity that should also be considered in the reauthorization of the Indian Health Care Improvement Act.

The Level of Need Funded Study published in December 1999 established that the personal medical services funding for Indian health was only 60 percent of the comparable services for federal employees used as a benchmark. It also compared funding needs within the 12 Areas of the IHS. This study shows that the Oklahoma Area receives the least per capita funding of any Area in the IHS. The Oklahoma Area per capita funding is only $856, compared to an average of $1,495 for all Areas of the IHS, which is only 60 percent of the $2,980 needed to have parity with the federal employee health care benefits.

The Cherokee Nation is served by two of the most underfunded Service Units in the country. Just to bring these two Service Units up to the 60 percent average funding level for the entire IHS requires additional federal funding of $16.6 million for the Claremore Service Unit and $11.6 million for the Tahlequah Service Unit. Thus a total of $28.2 million dollars more in federal appropriations is needed just to bring the Cherokee Nation up to the IHS average of 60 percent of the personal medical service needs. To fully fund these two Service Units would take $66 million. We note that these two Service Units provide health care for 52,780 users, including some from other tribes.

So, we urge you to expand your consideration of parity issues somewhere in this legislation.

Sec. 419. Co-insurance, Co-payments, Deductibles and Premiums

(b) Exemption from Premiums

We think that the concept here is good. However, the provisions in paragraph 1 should also apply to Medicare in paragraph 2.

(2) Medicare Enrollment Premium Penalties

We certainly support the wording in this section, but we believe it does not go far enough to assure that Indian elders have access to Medicare. As with the previous paragraph, we believe that members of federally-recognized tribes should have their Medicare Part B premiums and co-pays waived. Furthermore, many Indian elders have lived their entire lives in areas of extremely high unemployment where they have been unable to work the required quarters in jobs that would qualify them for Medicare. We believe that all Indian elders should be deemed eligible for Medicare. This is especially important in relation to the high rate of diabetes and end stage renal disease for which Medicare coverage is essential.

Sec. 423. Provisions Relating to Managed Care

This section is extremely important in the current health care environment in which managed care is the dominant form of third party payment.

(a) Recovery from Managed Care Plans

We support the intent of this section, but we believe that the wording needs some clarification. While the right of recovery is an important concept, we think it applies specifically to private sector health plans. It is confusing to roll the private sector plans in with the public sector plans with regard to billing for off-plan services. We support the provision in paragraph (e) which states that the Indian health organizations "shall have the right to be paid directly by the State agency administering" Medicaid and Child Health Insurance Plans. Paragraph (a) could be

read to suggest that Indian health organizations would bill the plans rather than the states for these programs.

The wording "reasonable costs" is subject to interpretation. We think it should be tied to a specific standard, such as "not less than the amount Medicare would pay the IHS for the same service."

(g) Prohibition

This section addresses the default assignment of Indians to Medicaid and Child Health Insurance managed care plans. We think this section should be strengthened in two ways, which would provide access to culturally competent care:

1. If an American Indian does not choose a plan, the default assignment will be to an Indian health provider; and
2. If an American Indian does choose a plan, they can change their assignment to an Indian health provider without being subject to a lock-in period.

Sec. 425. Indian Advisory Committees

While we support the provisions in this section, we want to see a statement that the advisory committees do not replace the requirement for government-to-government consultation between HCFA and tribal governments.

(b) Indian Medicaid Advisory Committees

Because each state has a different Medicaid program, we endorse the concept of a separate Indian Medicaid Advisory Committee for each state where there is an Indian health system. However, we believe this legislation should stipulate that the tribes in each state shall be part of the decision-making to determine the membership structure of the state advisory committee, along the lines of negotiated rule-making.

Title II - Conforming Amendments to the Social Security Act

Our copy of the legislation has a second Title II at the end of the bill. Many of the provisions in this section relate to the financing issues in Title IV. Therefore, we would like to

take the opportunity to comment on portions of this section. Specifically, we want to add our strongest endorsement to the following sections:

Sec. 202 (e) Treatment of Certain Programs

This technical amendment to the Social Security Act that would allow tribes to bill Medicare for outpatient services has been needed for a long time. We urge you to act on it even before passage of the Indian Health Care Improvement Act.

Sec. 203. Qualified Indian Health Program

Using a payment method that provides for full cost recovery is necessary in the Indian health system because there is nowhere to shift costs. Very few patients who seek services from the Indian health care system have private health insurance. The IHS is so underfunded that it should not be asked to absorb the costs of providing services to beneficiaries of other federal programs.

Title V - Health Services for Urban Indians

This title establishes urban Indian health programs so that health care services are accessible to urban Indians. This title gives the Secretary of DHHS, through the IHS, the authority to enter into contracts or grants to urban Indian organizations to help these agencies with establishing and administering health programs.

Approximately one-half of the Cherokee Nation tribal members live outside of our service area due to federal policies that encouraged relocation by the BIA as well as the lack of employment opportunities in rural Oklahoma. These Indians should not be penalized for living in urban areas. Therefore, the Cherokee Nation supports the urban Indian programs, in general, and the enhancements made in Title V. Specifically, we would like to comment on two of the sections:

Sec. 516. Urban Youth Treatment Center Demonstration. With the erosion of the quality of life from alcohol and substance abuse, especially in Indian youth, the Cherokee Nation supports this section whole-heartedly. With Native communities being plagued by alcohol and

substance abuse, it is causing havoc on Native families across the country. Alcohol continues to be an important risk factor associated with the top three killers of Native youth: accidents, suicide, and homicide. Native Americans have higher rates of alcohol and drug use than any other racial or ethnic group. Eighty-two percent of Native adolescents have used alcohol, compared to 66 percent of non-Native youth. Indian youth face many challenges in the urban setting and for the urban Indian programs to offer culturally competent residential settings for urban Indian youth will be much more effective. New monies are needed to fund this effort as well as adequate funding for the Youth Regional Treatment Control, one of which is operated by Cherokee Nation.

Sec. 518. Grants for Diabetes Prevention, Treatment and Control. Diabetes continues to be a growing problem in many American Indian and Alaska Native (AI/AN) communities with rates increasing rapidly. Diabetes is an epidemic among AI/AN and has been identified as a top health problem in all areas of the IHS. AI/AN are at a risk of 231 percent greater for diabetes mellitus than the U.S. all races' population. Diabetes is a major cause of morbidity (such as blindness, kidney failure, lower-extremity amputation, and cardiovascular disease) and premature mortality in AI/AN. Diabetes is the leading cause of patient visit to Cherokee Nation clinics.

In 1996, an estimated 63,400 AI/AN who receive care from IHS had diabetes. The prevalence of diabetes increases with age and is greater among women than men. With these alarming rates of diabetes among AI/AN, Cherokee Nation supports all diabetes programs. Increased funding is needed for the prevention and treatment of diabetes throughout Indian Country.

Title VI - Organizational Improvements

Indians have tried for many years to bring the much needed national attention and focus on the health status of AI/AN. There have been many failed attempts, but with our perseverance we believe that one day we will be able to achieve our goals.

The Cherokee Nation believes that the provisions in this will assist in our endeavors.

Sec. 601. Establishment of the IHS as an Agency of the Public Health Service. This section addresses the establishment of the IHS as an agency of the PHS. It covers the appointment of the Assistant Secretary of Indian Health by the President and confirmed by the Senate.

There is no doubt that in the competition for a priority in the federal budget; the IHS is losing out each year. Tribal governments have long supported elevating the status of the IHS Director in the hope that greater stature will enable IHS to more effectively advocate for the health needs of AI/AN. This is an accomplishment that will not only decrease the bureaucratic overhead, but will help Indian Country reach its health care goals.

This elevation is needed in order to further the unique government-to-government relationship between Indian tribes and the United States, facilitate advocacy for the development of Indian health policy, and promote consultation on matters related to Indian Health. This elevation will not only provide the necessary leadership within the Administration on Indian health issues, but will bring the much needed focus, national attention, and parity to the devastating health care status of AI/AN.

Sec. 602. Automated Management Information System. This section authorizes the Secretary through the Assistant Secretary of Indian Health to establish an automated management information system for all Indian health care providers to utilize.

This system is essential so as to record health data, justification for budget requests, and documentation of the level of need for IHS.

New language is proposed authorizing the IHS to enter into contracts, agreements or joint ventures with other federal agencies. It is our recommendation that tribal governments be included in this authorization, which would enhance the government-to-government relationship.

Furthermore, we must recognize that this will be a costly endeavor. Funding should not be diverted from our all to meager attempts at patient care. This item should be funded in the context of an appropriations bill that makes progress to close the gap created by unmet needs.

Conclusion

When the people living in the 14 counties of the Cherokee Nation turn on the news, they hear that the federal government has more than a trillion dollars in surplus and is spending billions on a missile defense system that doesn't work, and billions to provide health care for people living in other countries. We wonder why the good people in our Congress have forgotten their commitment to provide health services to American Indian and Alaska Native people. Could we just exchange one anti-ballistic missile for funding to alleviate the illness, pain and suffering in Indian Country? The reauthorization of the Indian Health Care Improvement Act is an important step forward. But it can only make a positive impact on the health of AI/AN if it is accompanied by an appropriations bill that provides funding to carry out the goals of the Act.

It has been said, "great nations, like great men, keep their promises." As I see it, S. 2526 simply allows Congress to fulfill the promises it has made to tribal leaders. The health of Indian people continues to lag that of other Americans. The members of this Committee are well aware that the health program is woefully underfunded. The total unmet need is $1.2 billion. This amount is needed to eliminate the *current* health deficiencies in Indian country. Indian tribes throughout the country, the National Congress of American Indians, the National Indian Health Board, and regional tribal organizations all strongly support this bill. The Cherokee Nation therefore urges the Committee to enable Congress to fulfill the promises it made to the Indian people in P.L 93-638.

After all, Cherokee families, our children and our elders are the ones who need health care. The Cherokee Nation takes great pride in delivering health services in our area just as well as, if not much better, than any federal agency or private provider ever could. This bill will enable us to make our health system more efficient and more responsive to the needs of our tribal members.

The Cherokee Nation looks forward to the day when it can come to this Committee with nothing but positive reports about the elevation of the health status of American Indians and about a true partnership between the IHS, Indian tribes, and urban Indian organizations.

S. 2526 furthers and strengthens Congress' historic self-determination, self-governance and tribal policies. It should become law.

Thank you Mr. Chairman and Members of the Committee, for the opportunity to testify in strong support of this important legislation.

THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES

Testimony of

Barbara Namias, President
National Council of Urban Indian Health

Before the
Senate Committee on Indian Affairs

On
The Indian Health Care Improvement Act
Reauthorization of 2000, S.2526

July 26, 2000

THE URBAN INDIAN HEALTH CARE STORY: THE NEED FOR SERVICES

"Between the intentions of the lawmakers and the reality of regulatory actions lies the *service gap* that confronts the urban Indian. The result is untold desperation and waste of human resources."

Final Report of the American Indian Policy Review Commission, Vol. 1, p. 436 (emphasis added).

I. INTRODUCTION

Honorable Chairman and Committee Members, my name is Barbara Namias, President of the National Council of Urban Indian Health (NCUIH). I am a member of the St. Regis Mohawk Tribe, and also the Health Director of the North American Indian Center of Boston. On behalf of NCUIH, and its 31 member programs, I would like to express our appreciation for this opportunity to testify before your Committee on the reauthorization of the Indian Health Care Improvement Act (IHCIA).

Founded in 1998, NCUIH is the only national membership organization of urban Indian health programs. NCUIH seeks, through education, training and advocacy, to meet the unique health care needs of the urban Indian population. Title V urban Indian health programs provide a wide range of health care and referral services in 34 cities, actively serving approximately 150,000 urban Indians per year.[1] NCUIH is the successor organization to the American Indian Health Care Association which provided advocacy and educational services on behalf of urban Indian health organizations for nearly 15 years prior to the establishment of NCUIH.

NCUIH'S Prior Testimony. On March 8, 2000, the former president of NCUIH, Kay Culbertson, presented detailed testimony on the technical aspects of the IHCIA. I will not repeat that detailed analysis here, except on the two issues left unresolved therein: the definition of "urban Indian" and the status of the Oklahoma City Clinic and the Tulsa Clinic.

In general, my testimony will focus on the unique circumstances of urban Indians, the Federal obligation to address urban Indian health care needs, and the ongoing need of urban Indians for health services.

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[1] According to the 1990 census, 62.3% of American Indians and Alaska Natives reside off reservation. At that time, that figure represented 1.39 million of the 2.24 million American Indians and Alaska Natives. The updated 1990 census identified 58% of American Indians and Alaska Natives as living in urban areas (the other off-reservation Indians live in rural areas). This percentage has probably increased significantly since 1990. See also attachments A and B (demographic charts).

II. NCUIH STRONGLY SUPPORTS THE NATIONAL STEERING COMMITTEE'S RECOMMENDATION BUT WITH CERTAIN REFINEMENTS ON MATTERS THAT RELATE TO URBAN INDIANS

NCUIH strongly supports the recommendations of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act which form the basis of S. 2526, although we are asking for a few important refinements.

NCUIH, on behalf of the urban Indian health care organizations, was an active participant in the activities of the National Steering Committee in developing the recommendations. This initiative brought together the Indian Health Service, Indian Tribes, and urban Indians in a united effort to develop sensible and effective amendments to the IHCIA, as well as certain other Federal laws which affect the provision of health care services to Indian populations (such as the entitlement programs Medicaid and Medicare, as well as the Federal Tort Claims Act). While some of the discussions were spirited, the parties worked together with the goal of speaking with one voice, achieving an extraordinary level of consensus.

NCUIH has several suggestions for refinements to S. 2526. NCUIH has been in discussion with other members of the National Steering Committee about achieving a consensus position on these suggestions and believes that such a consensus will be achieved. The first two suggestions are critical to the status and identity of urban Indians in Federal Indian health care policy; the second two are principally important for purposes of clarity. In the proposed amendments, new language is underlined; deleted language is struck out.

A. Critical Amendments Regarding the Status and Identity of Urban Indians in Federal Indian Health Care Policy. These first two amendments go directly to the core provision of health care support by the Federal government to urban Indians.

(1) First Suggested Amendment: The existing Indian Health Care Improvement Act includes urban Indians in the Congressional policy statement:

> "it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians *and urban Indians* and to provide all resources necessary to effect that policy.
>
> "(b) It is the intent of the Congress that the Nation meet the following health status objectives with respect to Indians *and urban Indians* by the year 2000:"

25 U.S.C. Section 1602(a)-(b) (emphasis added). S. 2526 does not include a reference to urban Indians in the equivalent paragraphs. Removing "urban Indians" from this important policy statement would imply that the Congress no longer considers the health status of urban Indians to be a national priority. We have been informed that this was an oversight and therefore recommend the restoration of the language as follows:

"SECTION 3. DECLARATION OF HEALTH OBJECTIVES

"Congress hereby declares that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to the American Indian people--

"(1) to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;"

(2) to raise the health status of Indians and urban Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2000, or any successor standards thereto;"

(2) Second Suggested Amendment. In the existing Indian Health Care Improvement Act, the definition of "Indian" includes members of federally recognized tribes and, for certain purposes, members of terminated tribes, state recognized tribes, tribes that may now or in the future be recognized, and Alaskan Natives, among others. The definition of "Urban Indian" includes members of all of these groups (including members of Federally recognized tribes) who reside in an urban center.

In S.2526, the definition of "urban Indian" was changed from that provided for under current law in a manner which would eliminate some Indians currently eligible for services at urban Indian programs. This has been explained as an unintended omission and there has been general consensus on the National Steering Committee to restore the original language. Set forth below is the consensus change for restoring the current law definition of "Urban Indian" to S. 2526:[2]

"SECTION 4. DEFINITIONS.

"(22) The term "urban Indian" means any individual who resides in an urban center and who—

"(A) regardless of whether such individual lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

"(B) is an Eskimo or Aleut or other Alaskan Native;

"(C) is considered by the Secretary of the Interior to be an Indian for any purpose; or

[2] This change restores the meaning but not the structure of the definition of "Indian" and "Urban Indian." Under current law, "Urban Indian" refers to certain exceptions found within the definition of "Indian;" now the definition of "Urban Indian" is being set out in full separately and the definition of "Indian" has been shortened as described in Section II.B.1, below.

"(D) is determined to be an Indian under regulations promulgated by the Secretary."

It is important, in taking into account the unique historical circumstances of urban Indians, to retain the definition found in current law. As discussed in Section IV. H below, the urban Indian community consists of Indians from a wide variety of backgrounds, almost all of whom can tie their urban existence to some Federal policy or action. Many of these Indians are in urban areas due to some traumatic disruption in their connection with their Tribes, or because something has happened to their Tribes (termination or marginalization such that they are not currently federal recognized). As a result, unlike the Indian population on reservations, most, but not all are members of federally recognized tribes. Yet they are all Indian; they are recognized as Indian by their community; their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.[3]

B. Clarifying Amendments. The final two proposed amendments are intended principally to ensure clarity when it comes to defining critical terms; no actual change in the meaning of the terms discussed here is intended by NCUIH.

(1) First Suggested Amendment. The definition of "Indian" has been substantially revised in S. 2526 from current law, principally by separating out sub-definitions which chiefly apply to urban Indians. NCUIH accepts the new structure of the definition, but has a

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[3] The Executive Director of the Seattle Indian Health Board, Ralph Forquera, M.P.H., commented eloquently on this issue in a May 24, 2000 letter to NCUIH:

> "There are two principle reasons why I believe that the definition should remain as is. First, the Act itself continues to address the health needs of all Indian people, not just those living on or near reservations. The redesign of the Indian Health Service in 1996 and adoption of the I/T/U model further supports this claim. Clearly the Congress intended for there to be a separation between 437 and 638. Thus, the adoption of the 638 language now, in my opinion, would tarnish the original Congressional intent by shifting the Act to a tribally based orientation.
>
> "Second, the conditions that lead to the original enactment of both the Act itself and Title V in particular have not changed. There remains a large and growing group of Indian people who are handicapped by poverty, inadequate education, and other socio-economic challenges that contribute to diminished health status. Many continue to be victimized by alcoholism, violence, and the myriad temptation that diminish one's capacity to achieve optimal health. The social dynamics that served to disenfranchise Indians throughout the century remain. Indians, particularly in cities, continue to struggle with identity and acceptance both within Indian Country and within the nation as a whole.
>
> "But perhaps the most compelling reason to continue the broader definition of Indian is the psychic benefits. The ability of urban programs to provide the gift of acceptance to those Indians who by circumstances or policy were denied their rightful identity as an Indian person is vital, in my opinion, to improving the health status of this group. Only in the past few years have I personally begun to appreciate the tremendous emotional burden many Indian people have had to bare by being denied their identity through structural limitations. Not knowing who you are is one thing; but knowing and not feeling accepted by your peers has devastated many Indian people. I have had the good fortune to witness the positive effect that acceptance can play in the lives of several here in Seattle. The health effect of this simple practice is enormous."

recommendation regarding the definition of "Indian." The definition used in S. 2526 is a cross-reference to the definition for "Indian" from the Indian Self-Determination and Education Assistance Act. NCUIH supports using the ISDEAA definition, but believes that it makes more sense, as a matter of clarity and good drafting, to spell-out the actual definition of a term than to have this legislation (S. 2526) define the term by referring to another act (Indian Self-Determination and Education Assistance Act) which the reader may or may not have readily available, or otherwise may have difficulty obtaining. Also, by using the actual definition of "Indian," as NCUIH proposes, any concern that a reference to the Indian Self-Determination and Education Assistance Act is intended, in some way, to incorporate some aspect of its policies and purposes into the wholly separate Indian Health Care Improvement Act, is eliminated. NCUIH's recommended language is set forth below:

"SECTION 4. DEFINITIONS.

"(10) INDIAN—The term "Indian" means a person who is a member of an Indian tribe ~~and "Indians" shall have meanings given such terms for purposes of the Indian Self-Determination and Education Assistance Act.~~"

(2) Second Suggested Amendment. The definition of "Indian tribe" has been changed in S. 2526 from current law, principally by removing a spelled-out definition of "Indian tribe" and replacing it with a cross-reference to the definition for "Indian tribe" from the Indian Self-Determination and Education Assistance Act. NCUIH supports using the ISDEAA definition, but believes that it makes more sense, as a matter of clarity and good drafting, to spell-out the actual definition of a term than to have this legislation (S. 2526) define the term by referring to another act (Indian Self-Determination and Education Assistance Act) which the reader may or may not have readily available, or otherwise may have difficulty obtaining. Also, by using the actual definition of "Indian tribe" as NCUIH proposes, any concern that a reference to the Indian Self-Determination and Education Assistance Act is intended, in some way, to incorporate some aspect of its policies and purposes into the wholly separate Indian Health Care Improvement Act, is eliminated. NCUIH's recommended language is set forth below:

"SECTION 4. DEFINITIONS.

"(12) INDIAN TRIBE – The term "Indian tribe" means any Indian tribe, band, nation or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians ~~shall have the meaning given such term in section 4(e) of the Indian Self-Determination and Education Assistance Act.~~"

C. Oklahoma City Clinic and Tulsa Clinic. Section 512 of S. 2526 is concerned with the status of the Oklahoma City Clinic and the Tulsa Clinic. S. 2526 would make the Tulsa Clinic a permanent program. NCUIH's supports making both the Tulsa Clinic and the Oklahoma City Clinic permanent programs.

D. Negotiated Rulemaking. NCUIH would like to note the negotiated rulemaking provisions in the S. 2526 and emphasize how important it is that there be urban Indian representation, as the bill provides, in those negotiations.

III. GUIDING PRINCIPLES FOR URBAN INDIAN HEALTH PROGRAMS

In 1994, urban Indian health providers, during the tenure of the American Indian Health Care Association - NCUIH's predecessor organization - met in San Diego and adopted four "Guiding Principles." These principles still hold true for NCUIH's current efforts on behalf of urban Indians and directly address the relationships between and among urban Indians, Indian Tribes and the Federal government.

A. Sovereignty of the Tribes. The first principle addresses the understanding of urban Indians regarding the central importance of tribal sovereignty and the government-to-government relationship between Tribes and the United States:

> **Sovereignty of the Tribes:** ***We believe that tribal sovereignty, based on government-to-government treaties and trust responsibilities, along with certain moral obligations, of the United States government, is the foundation for all Indian affairs, including health care.***

In the Steering Committee's deliberations, there was recognition of the importance of emphasizing the sovereignty of tribal governments and the Federal government's trust obligation to Tribes and tribal peoples. There was also a recognition of the historical circumstances, largely a result of Federal government actions and policies, which gave rise to urban Indian communities consisting of Indians from a wide variety of tribal backgrounds (these circumstances are discussed in Section IV).

Although Congress has been specific about its commitment to both Tribes and urban Indians,[4] we recognize that, despite our common interest in health services, Tribes and urban Indians generally occupy different places in Federal Indian policy. Federally recognized tribes have sovereignty and a trust relationship with the United States; as a result there are many different federal laws addressing that relationship in such areas as land, water, criminal justice, and jurisdiction, which have no applicability to urban Indians. Although most urban Indians belong to federally recognized tribes, urban Indians do not aspire as such to be recognized as having sovereign powers or as being in a government-to-government relationship with the United States.

B. All Indian People. The second principle addresses the reality of the urban Indian experience.

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[4] Congress has made clear, as set forth in the current Indian Health Care Improvement Act, "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and urban Indians and to provide all resources necessary to effect that policy." 25 U.S.C. Section 1602(a).

> **All Indian People.** ***We believe that all Indian people, regardless of tribal affiliation, blood quantum, or their place of residence are entitled to all the necessary health resources and services to achieve the highest possible health status.***

Many Indians, from many different tribes have ended up in urban areas. As described in greater detail in Section IV below, for a variety of reasons, mostly traceable to federal government action, they find themselves among the ranks of the urban poor. Most are members of Federally recognized tribes; some are not. Many among the latter have become so disconnected from their tribes that it is difficult for them to obtain tribal membership, or their tribes have been terminated or otherwise marginalized. Yet they are all Indian; they are recognized as Indian by their community; their circumstances are principally the result of Federal Indian policies; they are deserving, morally and legally, of support from the Federal government in achieving the highest possible health status.

C. Traditional Medicine. For urban Indians, as much as for reservation Indians, traditional medicine is critically important to maintaining a connection with tribal and cultural identity and plays an important role in a holistic approach to their health.

> **Traditional Medicine.** ***We believe that traditional Indian medicine is intrinsic to our culture and essential to a holistic approach to healing the body, mind, and spirit of our people.***

Urban Indians stand shoulder-to-shoulder with their reservation brothers and sisters on the critical importance of preserving and integrating traditional medicine into Indian health programs.

D. Unified Urban/Tribal Partnership. We believe in working closely with the Tribes.

> **Unified Urban/Tribal Partnership.** ***We believe that a unified Indian partnership is vital to assure access to comprehensive health services to achieve the highest possible health status for all Indian people.***

Many tribal peoples live in urban areas; some permanently, some periodically.[5] However, in many urban centers, it is not practical for any one tribal government to set up an outreach to only its own tribal members. In fact, "in some urban centers, there are as many as 40 tribal governments nearby, and representation of tribes on urban Indian programs might include over 80 different tribes."[6] The urban Indians have developed skills necessary for survival (if not

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[5] One Federal court has noted that the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." United States v. Raszkiewicz, 169 F.3d 459, 465 (7th Cir. 1999)

[6] U.S. Congress, Office of Technology Assessment, *Indian Health Care*, OTA-H-290 (Washington, DC: U.S. Government Printing Office, April 1986), p. 38.

yet prosperity) in the urban environment;[7] the tribes are the great repository of cultural tradition and knowledge. The practical approach is the current approach: working together, Tribes and urban Indian health organizations can provide the best possible health care for our people. The extraordinary level of cooperation in the work of the National Steering Committee is proof positive of the value of this approach.

IV. FEDERAL POLICIES AND THE URBAN INDIAN

> **"Most Indians who migrate to the cities say they would have preferred not to do so at all."**
>
> Final Report of the American Indian Policy Review Commission, Vol. 1., p. 436.[8]

The urban Indian is an Indian who has become physically separated from his or her traditional lands and people, generally due to Federal policies. Some of these federal policies were designed to force assimilation and to break-down tribal governments; others may have been intended, at some misguided level, to benefit Indians, but failed miserably. The result of this "course of dealing," however, is the same: a Federal obligation to urban Indians.[9]

A. The Federal Relocation of Indians. The BIA's Relocation program originated in the early 1950s as a response to adverse weather and economic conditions on the Navajo reservation. A limited program was initiated to relieve the distress by finding jobs for Navajos who wanted to work off the reservation. Little or no job opportunities existed on the reservation, so an employment campaign was developed for off-reservation employment. Shortly afterward, the

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[7] "The Committee views the health dilemma of urban Indians as a serious obstacle in their quest to become self-sufficient and participating citizens. Fortunately, an evolving Congressional policy addressed to this problem has served to provide the essential experience and information for the provisions contained in Title V. That evolving policy has been built on the concept of self-determination with the Indians themselves managing federally subsidized health efforts tailored to fit the health circumstances of Indian populations residing in specific urban centers." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) p. 2652 and 2752.

[8] For a more detailed summary of the history of off-reservation Indians see Attachment C, which is the relevant chapter from the Final Report of the American Indian Policy Review Commission.

[9] The unique legal relationship of the United States with Indian tribes and people is defined not only in the Constitution of the United States, treaties, statutes, Executive orders, and court decisions, but also in the "course of dealing" of the United States with Indians. As the Supreme Court noted in a major Indian law case, "[f]rom their very weakness and helplessness, so largely due to the *course of dealing* of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection and with it the power." *United States v. Kagama* (1886) (emphasis added). Congress acknowledged this in its findings to the Native American Housing Assistance and Self-Determination Act: "The Congress through treaties, statutes *and the general course of dealing* with Indian tribes, has assumed a trust responsibility . . . for working with tribes *and their members* to improve their housing conditions and good economic status so that they are able to take greater responsibility for their own economic condition." 25 U.S.C. 4101(4). Notably, NAHASDA also applies to state-recognized tribes. 25 U.S.C. 4103(12)(A).

BIA converted its Navajo program into a full-fledged Bureau of Indian Affairs program applicable to many Indian tribes.

The BIA employees who developed the program made many mistakes and miscalculations. Even before the 1950's had ended there was concern that many relocatees were experiencing great difficulty adjusting to life in a large city, or to their jobs. Some felt they were being stranded far away from home. Solving reservation economic problems by relocating Indians off of their tribal lands is roughly the equivalent of the Federal government, during the Depression, sending Americans oversee to find work – something the Federal government would never have done. Many understood the relocation program as just another form of "termination." A Jesuit priest on the Fort Belknap Reservation noted that relocation programs drained the reservation of much of its potential leadership, further weakening tribal governments.

All told, between 1953-1961, over 160,000 Indians were relocated to cities.[10] Where they quickly joined the ranks of the urban poor.[11] Set forth below is a description of the experience of Indians who relocated.

URBAN GENOCIDE - THE INDIAN IN THE CITY (excerpts)[12]

"The economic status of the reservation Indian is far below the poverty bracket. This is due to the lack of employment both on and off the reservations with the exception maybe of the larger cities. The main source of employment to be found on most reservations is working with the Bureau of Indian Affairs. In this way, the "Bureau" can instill its white culture on the Indians and eventually brainwash them into working against their own people. The reservation towns bordering the reservations can offer no employment for Indian people because of the great amount of racism, discrimination and prejudice that exist among the whites and other non-Indians.

"Consequently, the bad conditions and individual economic situations that have evolved from these indignities have forced the Indians to seek other sources of employment and education. With 75 percent of the Indian population unemployed for three generations, parents of Indian children could not, and still cannot afford to send them to public schools and have to depend on the government to educate them in "free" government boarding schools. Since it was a law to send their children to school, small children were forced to leave their parents and be shipped off to school thousands of miles away from their homes. These Indian boarding schools, established in various areas, were the prime weapons used to inculcate the white culture among the children or, in the common terms used at that time, "to civilize the barbarians." Any part of

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[10] 1992 Roundtable Conference, Urban Indian Health Programs, Indian Health Service, "Working in Unity Toward our Future." p.2.

[11] "Unfortunately, far too many Indians who move to the cities, because of inadequate academic and vocational skills, merely trade reservation poverty for urban poverty." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652, p. 2747.

[12] This document was obtained from the National Urban Indian Policy Coalition. The author of this piece is unknown.

the Indian culture was forbidden and the children were physically beaten if they used their native tongue or practiced their own dances. It has not been until just recently that this law has been officially lifted and is not in force, but the principle motive of de-Indianizing the Indians is still in effect.

"During the summer months while school is not in session, they send these Indian students to white homes to work as indentured servants. After graduation, they are sent directly out on relocation from the schools into the cities.

"Conveniently enough, the relocation program has been established to speed assimilation of Indians into the cities at this time of dead-end streets, reservation confusion and unemployment. Through this program they relocate the younger Indians from the ages of 18 to 36 on direct employment or vocational training. It is a one-way ticket to the city in hopes that you will melt with the melting pot and forget you are Indian or still have a reservation that the white man does not have yet.

"Numerous problems have developed as the result of the "dislocation program," therefore the following chapters will focus on the urban Indian situation.

What Happens to the Indians After Arrival in the Cities

"On arrival to the city on relocation, the individual Indian has in his possession an envelope with orders and instructions, telling where to go and what to do. First of all, he is to report to the Bureau of Indian Affairs if he arrives during office hours. If not, he reports to a BIA-approved hotel until the next day if he has any money.

"If they have time to see you the first day, they dole out a small amount of money to last until the end of the month if he is on the training program or until the next week if he is seeking employment. If they do not have time to see him the first day, he is to come back the following day at office hours and maybe some one will see him. In the meantime, he can sleep in the park or walk the lone deserted streets all night long.

"When he is received at the BIA headquarters in the city, he attends a short orientation period and an elderly lady will counsel him about sex and how to dial "0" for the operator on the telephone. A brief question and answer period follows and he is told to come back the next day at eight AM or to report to his designated school.

"The BIA locates his place of residence in the city and he is required to stay there if he is a student. They will discontinue his subsistence if he opposes and he will not be eligible for any more aid.

"The vocational school he is sent to may not be the particular training he originally signed up for back on the reservation, but this is the school he is required to attend.

"If the relocatee signed up for direct employment, he must take the first job available even if it is not his trade or type of work he wants. He is told it will be temporary until the type

of job he wants comes up but after he receives his first salary on his temporary janitor job, he is cut off their records and cannot receive any additional help after he quits, gets fired or the job runs out.

"The "Bureau" pays the student's tuition in the vocational school directly to the school. The student receives subsistence twice a month, doled out in payments of $74.00. From this amount, he must budget $59.00 per month per rent, and the other $15.00 must be divided into his expenses for food, cab fare, medical care, clothes and whatever else that should develop during the month. This budget was made up in 1953 when the program first developed and has not taken into consideration the rises in living and the area or city he is in. California has the highest cost of living especially in San Francisco, which is the central concentration point of relocatees coming from every reservation in existence today. This income is far below the poverty bracket nation-wide, yet this is the "help" the Indian Bureau is giving.

"All persons on the relocation program are issued a medical card which they can present to a physician and receive medical help up to a six-month period. The only problem here is that these medical cards only guarantee to pay $4.00 of the entire bill when the office calls alone are $5.00 at the very minimum.

What Problems They Face and Why

"The cultural background of the American Indians differs extremely from the white culture, creating a problem of communication between the two. Not only this, but the Indian culture has also been corrupted, bringing about a drastic change of social environment. This disintegration of culture has been attributed to disturbing early experiences in school, the generally poor level of education, poverty and the ambivalent position of the government in relation to the Indian.

"Prejudice and discrimination which does exist near reservations or anyplace where there is a large concentration of Indians, (although now in the city and away from being singled out as being an Indian), tends to have developed hostile and stereo-typed attitudes towards the other groups of society. The Indians have also collectively experienced a deterioration of personality, self-doubt, self-hate, impulsive and suspicious behavior, feelings of inferiority, deviant behavior, mental illness and suicidal tendencies.

"Depending on the environmental background, these adverse behaviors vary. Individual exceptions are due to the degree of orientation to the white culture or restored self-image through education.

"In dealing with the many Indian people who go through the BIA agencies, or any other type of agency established in the cities for employment or vocational training, the employees lack the experience of knowing the type of environment the individual Indian has been subject to and they do not know how to handle his particular situation. In many cases even where minority people hold agency positions, generally, they have developed superiority attitudes over the people they are trying to help and therefore stunt their full capabilities for helping others.

"[Many businesses] resent the BIA in its assistance of seeking employment for the Indian relocatees. This is due to the business' general dislike of any form of government transactions or to be told how to run their business concerns. This creates a great amount of conflict and the BIA, in order to retain a certain amount of prestige, often finds the Indian relocatee employment with a business concern that pays a low wage scale, hard labor with no company obligations, such as insurance policies, sick leave and vacation with pay. These small businesses often take no safety precautions and are constantly hood-winking the safety inspectors. Consequently, the Indian relocatees are more or less siding with the illegal aspects of the concern in which they are employed in order to retain their jobs. Employment competition is great and the relocatees can be dismissed from their job for little or no cause at all, and they are often plagued by this fear of being fired.

"In the event that a relocatee is fired for one reason or another and needs assistance, he cannot go back to the BIA for further help. The BIA tells him that his files have been sent back to his agency and they have no more funds or time to help him because their hands are tied with the other relocatees who are coming in.

"The budget set up for financing a student in vocational training are not only inadequate for one person's needs, but are not set to the area standards of living. In other words, they are transformed from one pocket of poverty to another, which in this case would be from a reservation to an urban ghetto.

"The vocational schools that Indian relocatees are sent to, in most cases are not accredited and after graduation from one of these schools, the relocatee cannot obtain a job. Most of the teachers in vocational schools are not qualified teachers, and there is a great shortage of instruction. The BIA gives the schools extra money for materials yet the conditions and facilities in these schools are still very bad. The students come out of these schools unqualified and inexperienced in the type of work for which they thought they had been trained and cannot find suitable employment.

"There are more and more students who are sick and tired of being treated as second-class people who do want to get a decent education and go to junior colleges and universities. The biggest problem here is not being able to get any finances, "Bureau" or otherwise. Also, Indian students' second-rate educations do not prepare them well enough for college work. Most reservation Indians are subject to irregular school and employment backgrounds and a great majority of the younger Indians have criminal or prison records. This does not mean that they cannot do the work academically; but, basically, they have never had the full opportunity to do so.

"The Bureau of Indian Affairs sends newly-arrived relocatees to unsanitary, immoral, crowded and unsafe places of residence. If the student wants to leave these conditions, the landlord promptly calls the BIA about the matter and the student is required to live there or have his subsistence discontinued. In one of the girls' boarding homes the landlady encouraged parties and drinking and let the girls' boyfriends come over. Then she would go into their rooms and take pictures of the different couples sleeping together. If the girls wanted to leave, she would then threaten to blackmail them with the pictures she had and in this way would keep her

business. A business college for female relocatees also housed the students, putting four girls to one small room and charging $100 per person, not including food or utilities. This establishment also received additional money from the BIA for recreational purposes which the girls never did see. If the girls tried to leave their residence, they were threatened with expulsion from the business college and have their subsistence discontinued. Most of these young Indian girls were between the ages of 18 to 20 years, who were eventually expelled for little or no reason and left to roam the city streets. Individual follow-up showed that 80 percent of these girls got pregnant, were drinking excessively and were living with men from time to time. This college is still in operation receiving relocatees from the Bureau of Indian Affairs.

"A boys' boarding house in the city was over-crowded with four bunks to a room, no studying facilities, unsanitary conditions, inadequate food and displaying a sign in the front of the house, CONDEMNED.

"These are typical living conditions, Indian youth are subject to when placed in the city through relocation. When a young Indian approached a BIA counselor why they had to live under such adverse conditions and was told, "The filthiest conditions you Indians are put under, the more at home you will be."

"Landlords and vocational schools are getting wise to the BIA and are making the largest profit and racket out of the Indian business at the cost of young Indian lives.

"Indian health is generally poor due to the economic standards and lack of proper diet and nutrition. Free medical facilities are provided on all reservations due to the unsatisfactory health conditions. Tuberculosis, cirrhosis of the liver, sugar diabetes, and trichoma are a few of the more prevalent diseases which Indian people are susceptible to. Trichoma, which is an eye disease, is very rarely heard of among Indians. Poverty conditions breed diseases.

"The BIA believes that when an Indian leaves the reservation, he suddenly leaves his "Indianness" and becomes a healthy, happy human being, and needs no more of the medical services he had before. Consequently, Indian health in the city becomes twice as bad as it might have been before because he cannot afford good medical care.

"Pregnant Indian women risk possibly losing their child by having to return to the reservation their last month so that they can receive medical care upon delivery of their baby.

"From the time Indians were victims of wars, they lost their identity which comes from pride and self-esteem. Indians became a lost people exhibiting schizoid behavior at times. An Indian who does not like himself, does not like other Indians because he can see himself reflected in the others. An Indian suffers from inferiority plus self-hate that leads to trying to escape these unbearable conditions. By escaping, he is rejecting the society that has made him this way. His means of escape is either through alcohol or suicide which are 100 percent times higher than the national average among the American Indians.

"An internal problem of self-identity and lost culture plus an external problem of discrimination and racism by people in power has suppressed and made what is left of the American Indian today."

Today, the children, grandchildren and great-grandchildren of the 160,000 Indians relocated by the BIA are still in the cities. They maintain their Indian identity even if, in some cases, these "descendants have been unable to re-establish ties (including membership) with their tribes."[13]

B. Failure of Federal Efforts to Economically Develop the Reservations. The second major reason Indians have moved to the city is the near total failure of Federal programs to promote economic development on Indian lands, coupled with the ongoing success of the Federal efforts in the 1800's to undermine the economic way of life of Indian peoples, locking nearly all Indians into hopeless poverty which still plagues most reservations today. The long history of treaty-breaking by the Federal government is an important part of this tale. As a result, out of desperation, a number of Indians have left their homelands to go to the cities in search of work, even without the dubious benefit of the BIA's relocation program. Generally, these Indians were no better equipped to handle life in the city than the BIA relocatees and quickly joined the ranks of the urban poor. Congress has noted the correlation between the failure of Federal economic policies and the swelling of the ranks of urban Indians: "It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."[14]

C. Termination of Tribes. In 1953, Congress adopted a policy of terminating the Federal relationship with Indian tribes. Essentially, this was an abrogation of the Federal government's numerous commitments, in treaties, laws, executive orders, and through the "course of dealing" with Tribes, to protect their interests. Many tribes were coerced to accept termination in order to receive money from settlements for claims against the United States for misappropriation of tribal land, water or mineral rights in violation of treaties.[15] The results of termination were devastating: having lost Federal support, and without tribal sovereign authority over an established land basis, and with tribal members no longer eligible for Federal programs and IHS services, the Tribes collapsed. Some members remained in the area of their old reservations; many went to the cities, where they, too, joined the ranks of the urban poor.

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[13] See Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 22-23.

[14] Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652,at p. 2754.

[15] Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 23.

D. Indian Patriotism -- World War I and World War II. Many Indians served the United States in time of war[16] and, subsequently, were stationed in or near urban centers. At the end of their service to the United States, seeing the poor economic conditions on their reservations (resulting from the Federal war on Indians), many chose not to go back. The fact that they chose to stay in an urban area did not make them any less Indian, nor did it reduce the Federal government's obligation to them.

E. The General Allotment Act. The General Allotment Act ("Dawes Act") had two principal goals: (1) by allocating communal tribal land to individual Indians it would breakdown the authority of the tribal governments while encouraging the assimilation of Indians as farmers into mainstream American culture; and (2) it provided for unalloted land (two-thirds of the Indian land base) to be transferred to non-Indians. CITE. The General Allotment Act succeeded at transferring the majority of Indian land to non-Indians and further disrupting tribal culture. For the purposes of this testimony, we only need to note that some Indians who received allotments became U.S. Citizens and, after losing their lands, moved into nearby cities and towns.

F. Non-Indian Adoption of Indian Children. The common practice of adopting Indian children into non-Indian families has created another group of Indians in urban areas who, because of the racial bias of the courts, have lost their core cultural connection with their tribal people and homelands. Many of the adopted Indians have successfully sought to restore those connections, but because of their upbringing are likely to remain in urban areas.[17]

G. Boarding Schools. The Federal program of taking Indian children and educating them away from their reservations in boarding schools where they were prohibited from speaking their native language and otherwise subject to harsh treatment, created a group of Indians who struggled to fit back into the reservation environment. Eventually, some moved to the cities. The boarding school philosophy of "Kill the Indian, Save the Man" epitomizes the thinking behind this approach and the racist Federal effort to assimilate American Indians which, as a result, led to a number of Indians moving to urban areas.

H. The Fracturing of the Indian Nations. The result of these, and other Federal Indian policies, has been the fracturing of Indian tribes and the creation, in the urban setting, of highly diverse Indian communities with members who fall into one or more of the following categories: Federal relocatees; economic hardship refugees; members of Federally recognized tribes, terminated tribes, state recognized tribes, and unrecognized Tribes (that is, unrecognized by the Federal government);[18] and adoptees.

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[16] It is in part because of their gallant service in World War I that the U.S. Congress granted U.S. citizenship as a group to American Indians in 1924.

[17] In recognition of the severity of this problem, Congress passed in 1978 the Indian Child Welfare Act to give Tribes and Indian parents a greater say in the adoption process for Indian children. See Indian Child Welfare Act of 1978, 25 U.S.C. Sections 1901-1963.

[18] There are still scores of tribes working their way through the byzantine and labyrinthine acknowledgement process, which is widely criticized for its glacial pace and alleged bias against certain Indian groups. Some tribes, like the Lumbee Tribe of North Carolina, have been declared ineligible to go through the administrative process and,

V. THE FEDERAL GOVERNMENT AND THE PROVISION OF HEALTH CARE TO URBAN INDIANS

The Congress has long recognized that its obligation to provide health care for Indians, includes providing health care off the reservation.

> "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation.* Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and *the responsibility for the provision of health care services follows them there.*"

Senate Report 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, p. 25 (emphasis added).[19] Congress has "a responsibility to assist" urban Indians in achieving "a life of decency and self-sufficiency" and has acknowledged that "[i]t is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs which failed to provide the Indian with an improved lifestyle on the reservation have also failed to provide him with the vital skills necessary to succeed in the cities." House Report No. 94-1026 on Pub. Law 94-437, p. 116 (April 9, 1976).

The Supreme Court has also acknowledged the duty of the Federal government to Indians, no matter where located: "The overriding duty of our Federal Government to deal fairly

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therefore, are awaiting Congressional action on their long-prepared, extensively documented petition for federal recognition.

[19] "The American Indian has demonstrated all too clearly, despite his recent movement to urban centers, that he is not content to be absorbed in the mainstream of society and become another urban poverty statistic. He has demonstrated the strength and fiber of strong cultural and social ties by maintaining an Indian identity in many of the Nation's largest metropolitan centers. Yet, at the same time, he aspires to the same goal of all citizens—a life of decency and self-sufficiency. The Committee believes that the Congress has an opportunity and a responsibility to assist him in achieving this goal. It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."

"The Committee is committed to rectifying these errors in Federal policy relating to health care through the provisions of title V of H.R. 2525. Building on the experience of previous Congressionally-approved urban Indian health prospects and the new provisions of title V, urban Indians should be able to begin exercising maximum self-determination and local control in establishing their own health programs."

Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652 at p. 2754.

with Indians *wherever located* has been recognized by this Court on many occasions." *Morton v. Ruiz*, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); and *Board of County Comm'rs v. Seber*, 318 U.S. 705 (1943). In other areas, such as housing, the Federal courts have found that the trust responsibility operates in urban Indian programs. "Plaintiffs urge that the trust doctrine requires HUD to affirmatively encourage urban Indian housing rather than dismantle it where it exists. The Court generally agrees." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987).[20]

Congress enshrined its commitment to urban Indians in the Indian Health Care Improvement Act where it provided:

> "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians *and urban Indians* and to provide all resources necessary to effect that policy"

25 U.S.C. Section 1602(a)(emphasis added). In so doing, Congress has articulated a policy encompassing a broad spectrum of "American Indian people." Similarly, in the Snyder Act, which for many years was the principal legislation authorizing health care services for American Indians, Congress broadly stated its commitment by providing that funds shall be expended " for the benefit, care and assistance of the Indians *throughout* the United States for the following purposes: . . . For relief of distress and conservation of health." 25 U.S.C. Section 13 (emphasis added).

The courts have also stated that there is a trust responsibility for individual Indians. "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members living collectively or individually, on or off the reservation.*" *Little Earth of United Tribes, Inc. v. U.S. Department of Justice*, 675 F. Supp. 497, 535 (D. Minn. 1987)(emphasis added). "In light of the broad scope of the trust doctrine, it is not surprising *that it can extend to Indians individually*, as well as collectively, *and off the reservation*, as well as on it." *St. Paul Intertribal Housing Board v. Reynolds*, 564 F. Supp. 1408, 1413 (D. Minn. 1983) (emphasis added).

> "As the history of the trust doctrine shows, the doctrine is not static and sharply delineated, but rather is a flexible doctrine which has changed and adapted to meet the changing needs of the Indian community. This is to be expected in the development of any guardian-ward relationship. *The increasing urbanization of American Indians has created new problems for Indian tribes and*

[20] Federal responsibility for Indian health care is frequently declared "primary" but it is not exclusive and preemptive of state responsibility. See *McNabb v. Bowen*, 829 F.2d 787, 792 (9th Cir. 1987). Congress enunciated its objective with regard to urban Indians in a 1976 House Report: "To assist urban Indians both to gain access to those community health resources available to them as citizens and to provide primary health care services where those resources are inadequate or inaccessible." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cond Cong. & Admin. News (USCAN) 2652, 2657.

> *tribal members.* One of the most acute is the need for adequate urban housing. Both Congress and Minnesota Legislature have recognized this. The Board's program, as adopted by the Agency, is an Indian created and supported approach to Indian housing problems. *This court must conclude that the [urban Indian housing] program falls within the scope of the trust doctrine . . . .*"
>
> Id. At 1414-1415 (emphasis added).

This Federal government's responsibility to urban Indians is rooted in basic principles of Federal Indian law. The United States has entered into hundreds of treaties with tribes from 1787 to 1871. In almost all of these treaties, the Indians gave up land in exchange for promises. These promises included a guarantee that the United States would create a permanent reservation for Indian tribes and would protect the safety and well-being of tribal members. The Supreme Court has held that such promises created a trust relationship between the United States and Indians resembling that of a ward to a guardian. See *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). As a result, the Federal government owes a duty of loyalty to Indians. In interpreting treaties and statutes, the U.S. Supreme Court has established "canons of construction" that provide that: (1) ambiguities must be resolved in favor of the Indians; (2) Indian treaties and statutes must be interpreted as the Indians would have understood them; and (3) Indian treaties and statutes must be construed liberally in favor of the Indians. See *Felix S. Cohen's Handbook of Federal Indian Law*, (1982 ed.) p. 221-225. Congress, in applying its plenary (full and complete) power over Indian affairs, consistent with the trust responsibility and as interpreted pursuant to the canons of construction, has enacted legislation addressing the needs of off-reservation Indians.

The Federal courts have also found, that the United States can have an obligation to state-recognized tribes under Federal law. See *Joint Tribal Council of Passamaquoddy v. Morton*, 528 F.2d 370 (1st Cir. 1975). Congress has provided, not only in the IHCIA,[21] but also in NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

VI. BARRIERS TO MAINSTREAM HEALTH CARE EXPERIENCED BY URBAN INDIANS[22]

> **"The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for**

[21] As originally conceived, the purpose of the Indian Health Care Improvement Act was to extend IHS services to Indians who live in urban centers. Very quickly, the proposal evolved into a general effort to upgrade the IHS. See, *A Political History of the Indian Health Service*, Bergman, Grossman, Erdrich, Todd and Forquera, The Milbank Quarterly, Vol. 77, No. 4, 1999.

[22] This section is based on the September 30, 1989 report prepared for the American Indian Health Care Association, by Ruth Hograbe, R.D., M.P.H., Program Analyst and Donna Isham, Program Analyst. The framework for the report is the 1988 report Minority Health in Michigan: Closing the Gap.

> **subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the *service gap* reveals itself again."**
>
> Final Report of the American Indian Policy Review Commission, p. 437 (emphasis added).

The status of Urban Indian health is as poor as that for reservation Indians.[23] This section describes the many barriers that are still faced by Urban Indians in their efforts to access adequate health care in the urban environment:

Physical/geographic barriers can include (1) telephone availability; less access to transportation; and (3) high mobility. Many Native Americans do not have phones, increasing the difficulty in making appointments. For example, in Arizona, thirty percent of urban Indians have no household access to phone services. Indian people have much less access to private vehicles than the general population. Not having a vehicle creates barriers for people who must make arrangements with others to bring them to appointments. Public transportation (if available) makes for a longer travel time and can be costly. The high mobility of Indian people is another barrier to care. People who move often are not able to follow with the same provider, and this disrupts continuity of care and can lead to a decrease in the quality of care. When a person moves to another area, they must go through the system again to qualify for benefits, locate a provider, and receive care. In addition, movement back and forth between the reservation is common, which can significantly affect the ability of health professionals to provide prompt, quality follow-up care.

Financial/Economic barriers also contribute to the poor quality of urban Indian health care. People who do not have the resources, either through insurance or out-of-pocket, to pay for prevention and early intervention care may delay seeking treatment until a disease or condition has advanced to the stage where treatment is more costly and the probability of survival or correction is lower.

Medicaid is available for urban Indians, but difficult to access. Applying for Medicaid or other medical assistance is a long and detailed process, presenting many barriers to people who don't understand the system or lack the necessary skills to complete the paperwork involved. Furthermore, the required documentation is difficult for many urban Indians to obtain. For example, if one does not have a car, one may not have a drivers license. With high mobility among urban Indians, there is likely to be no documentation with the current address; or if they have just moved to the city from the reservation, there may be no birth certificate or identification. Once an individual is accepted, access to care is not guaranteed. Because of Medicaid reimbursement rates and restrictions, many providers are reluctant to accept Medicaid patients.

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[23] See Attachment D for a leading study on Urban Indian health: *Health Status of Urban American Indians and Alaska Natives*, Grossman et. al, Journal of the American Medical Association, Vol. 271, No. 11, p. 845.

Health insurance coverage does not automatically remove financial barriers to care. Many persons, particularly those employed at or near minimum wage, have coverage through plans that do not cover preventive or major medical care. While professional positions generally provide health insurance, service and laborer positions generally do not. Urban Indians hold more of those occupations that do not provide health insurance benefits. Deductibles and co-payments are high enough that many persons who do have health insurance cannot afford to pay them and consequently do not seek care.

No insurance or assistance is another common barrier. Those who have no means to pay for care are often turned away. There is a high rate of urban Indians who are uninsured. For example, in Boston, 87% of the Boston Indian Center's clients have no health insurance, and two out of every three urban Indians in Arizona are uninsured.

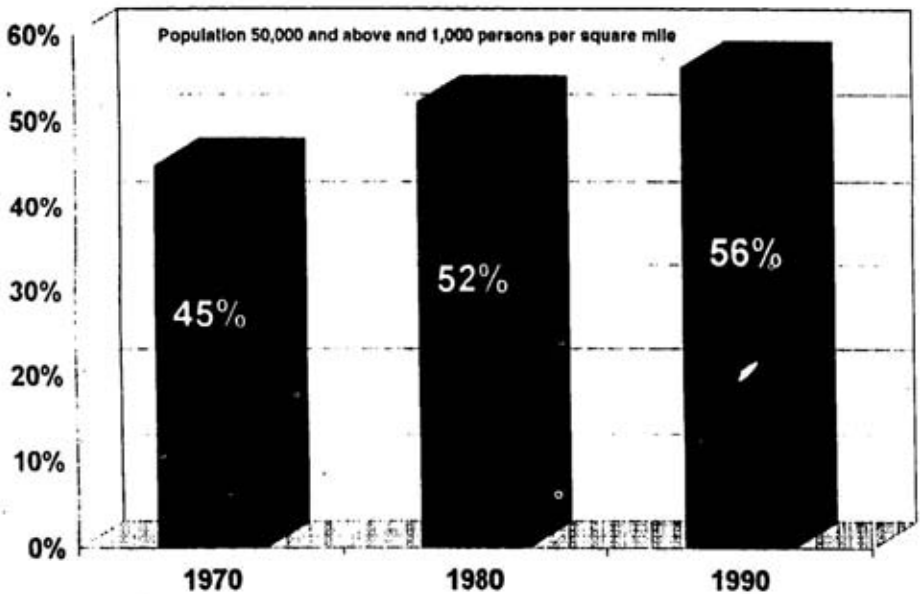
Emergency room use is high among the poor, minorities and the uninsured. Unfortunately, emergency room use as a primary medical resource is costly and compromises quality care. Follow-up and preventive services are not possible with emergency room personnel serving as primary care providers. In Arizona, urban Indians use the emergency room 250% more often than the general public.

Cultural/structural barriers also exist for urban Indians receiving health care. The Indian Health Service conducted a survey which concluded that the majority of state, county and city health departments do not have the resources to meet the health care needs of urban Indians. Major stumbling blocks are inadequate funds and lack of staff trained to work with American Indians in a culturally sensitive way. Indians may be reluctant or unable to describe their health needs to strangers outside their own culture. Frequently, mainstream providers misunderstand or misinterpret the reticence and stoicism of some Indians. Other factors include a lack of trained Indian health professionals that get placed in urban Indian health programs and inadequate Indian outreach.

X. CONCLUSION

Notwithstanding all the difficulties, urban Indian health organizations, working with limited funds, have made a great difference in addressing the health care service gap for urban Indians. There is much more work to be done. NCUIH thanks the Committee for its support in the past. NCUIH also thanks the Committee for this opportunity to provide testimony on the reauthorization of the Indian Health Care Improvement Act. This legislation will have far-reaching consequences for the health care of American Indians, including urban Indians. NCUIH urges the Committee to support the proposed amendments to IHCIA developed by the National Steering Committee, with NCUIH's proposed refinements. They provide an essential basis for improving the health care of America's native peoples.

CENSUS 1970, 1980, 1990
U.S. INDIAN POPULATION DISTRIBUTION
INSIDE URBANIZED AREAS



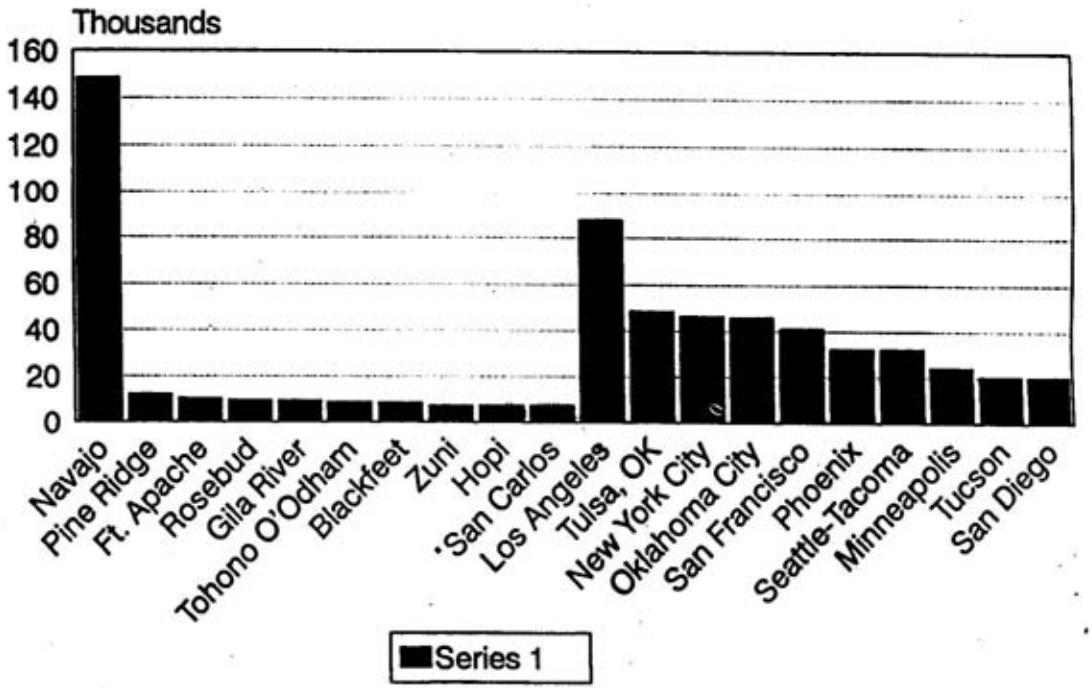
MC: Grants

R/8/94

Exhibit A

10 Largest Indian Reservations

and 10 Largest Urban Indian Population Cities



1990 Census

Exhibit B

Exhibit C

[COMMITTEE PRINT]

AMERICAN INDIAN POLICY REVIEW COMMISSION

FINAL REPORT

SUBMITTED TO CONGRESS
MAY 17, 1977

VOLUME ONE OF TWO VOLUMES

Printed for the Use of the
American Indian Policy Review Commission

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1977

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

CHAPTER NINE

OFF-RESERVATION INDIANS

Overview

Almost half of the United States Indian population lives outside the boundaries of Indian reservations. In 1970, 340,000 lived in cities and six cities had Indian populations which are larger than those of any reservation except the Navajo Reservation.[1]

Many of these people moved to cities because of Federal policies. The earliest movements of tribal people away from tribal lands were often the indirect result of policies which diminished the reservation land base to such an extent that Indians had to find homes elsewhere. Educational policies added to the trend by removing Indian children from their homes to off-reservation boarding schools where the children were taught skills which could not be used on reservations. Policies which neglected reservation development, of course, made reservations undesirable places to remain and also affected migration. Some policies, particularly following World War II, were more directly responsible for relocating Indians away from reservations. In addition to robbing reservations of some of their best talent, these policies have resulted in dire circumstances for the large numbers of Indian people who find themselves in urban ghettoes, today.

Despite the fact that the Federal Government must assume some responsibility for the present-day problems of urban Indians, the Government has actually refused to extend those services to urban Indians which they would otherwise receive if they lived on their reservations. Urban Indians do not receive the special Federal programs which are directed to Indians. Strangely enough, they often do not receive the services directed to non-Indians, either. Local, State and county welfare programs often refuse to serve Indians on the grounds that they are the responsibility of the Federal Government.

In this situation, the development of Indian community service centers has been the one optimistic factor. The Federal Government offers these centers little encouragement, however, and they become entangled in bureaucratic and jurisdictional fights.

New policy directions can have a very clear beneficial impact on the desperate urban Indian situation if administrative programs utilize and encourage urban Indian centers.

History[2]

This review of off-reservation Indian history will examine the ways Federal policies have splintered tribes and either forced or encouraged

[1] See A. Levitan and William B. Johnston, Indian Giving (Baltimore, 1975), 5-8.

Indians to move away from reservations in an effort to end the "Indian problem." It will also show how these moves have not solved the problems of poor health, poverty, limited employment opportunities, poor education, and alienation, but have merely transferred them to rural and urban settings.

In the late 19th century, after the Federal Government had succeeded in reducing Indian tribal holdings to small reservations, the policies of neglect, dependency, and assimilation were established. While there were some meager efforts at "reservation development," no significant system of economic and cultural protection was created to permit Indian tribes economic viability and independence. Reservations were often viewed as camps where assimilative tools would be provided prior to the Indian's dispersal among the white population.

Even reservations, however, posed a threat to the Federal Government because they provided a place where Indian people could not be effectively kept from maintaining their identity and culture. So, attempts were made to parcel out tribal lands to Indian individuals in an effort to destroy the communal cohesiveness of tribal society. The continuing assumption on the part of the Federal Government was that assimilation was the Indian's fate. Legislation was based on this assumption.

One of the most obvious examples of Federal action which broke up reservations, strained tribal cohesion, and encouraged subsequent migration of thousands of Indians to other areas was the General Allotment Act of 1887.[2] Indeed, it is not inaccurate to say that the migration of the Indians was a calculated result of this legislation.

The General Allotment Act was, of course, just one example of a long line of Federal legislation and administrative actions which were either designed to or inadvertently resulted in dispossessing Indians of their lands and driving them to seek jobs off the reservation.[3] Oftentimes, the Federal Government was the decisive influence weakening (and sometimes dissolving) [4] the tribal governing structures; it stood by while most of the Indians' choice lands were taken from their control and the resources from the remaining lands were destroyed; it moved Indians off the reservation for job training and employment. More often than not, job training in the cities turned out to be irrelevant, employment opportunities were nonexistent, and furthermore, the Federal Government neglected to provide meaningful assistance in housing, education, or health. As the final insult to those Indians who were victims of this concerted campaign to assimilate them, the Federal Government refused and largely still refuses to recognize its

[1] This historical review is condensed from an extensive history researched and written by Dennis Carroll for Task Force Eight.

[2] 24 Stat. 388.

[3] Also during the 1870's, the Federal Government began the Indian boarding school system which was "designed to separate a child from his reservation and family, strip him of his tribal love and mores, force the complete abandonment of his native language and prepare him for never again returning to his people." [U.S. Cong. Senate Committee on Labor and Public Welfare, Indian Education: A National Tragedy—A National Challenge, S. Rept. No. 91-501, 91st Cong., 2d sess. 12 (1969).] Some 20 years later, the Indian Commissioner stated that it was the "settled policy of the Government to break up reservations, settle Indians upon their own homesteads, incorporate them into the national life, and deal with them not as nations or tribes or bands, but as individual citizens." Rep. Comm. Ind. Aff., 1890 at VI.

[4] Felix Cohen described the systematical destruction of tribal governing structure and powers of the Five Civilized Tribes. F. Cohen, Handbook of Federal Indian Law, 427-436 (1942 ed.).

responsibility to provide them with the services they would receive on their reservations.

Education through the off-reservation boarding school was another method utilized to alienate Indian people from their culture. This educational model for Indian youth was directed at developing young men and women who could join the mainstream of white, Christian society. Instead, it left a legacy of frustration, depression, and alienation that made Indians unable to pursue the traditions of their fathers, but left them unequipped to participate in white-dominated economy.

The increasing number of Indian people living off-reservation was noticed in two Indian policy studies in the 1920's. The Senate Subcommittee on Indian Affairs' Survey of the Conditions of the Indians of the United States was followed by the well-known Meriam Report.

The Subcommittee conducted and published hearings across the United States, and largely provided the data base for the more concise Meriam Report. The subcommittee's hearings in California were particularly directed at the burgeoning problem of urban Indians. The Government was beginning to notice a new problem area in Indian affairs, but responsive policies would not be instituted within the next half-century. Whatever insights might have been gained from hearing testimony were lost when the Meriam Report published its chapter on "Migrated Indians", and relied on the material presented by Indians' employers rather than the Indians themselves. On this choice of information, the Meriam Report recommended that "no effort be devoted toward building up an independent organization in such cities for migrated Indians, but rather toward establishing cooperative relations with existing agencies which serve the population as a whole."[1]

The Snyder Act of 1921 had given the Commissioner of the Bureau of Indian Affairs broad latitude in spending appropriations for Indian affairs and in developing programs to meet Indians' needs. The legislation simply stated that appropriations were to be used for "Indians throughout the United States." Certainly that clause is broad enough to include those Indians who were forced away from reservations by bad policies, by Federal encouragement, or by economic needs, but the Bureau did not choose to view its role in so expansive a way. The Meriam Report, no doubt, gave scholarly support to this bureaucratic timidness. For many years, the Bureau's failure to serve the increasing urban Indian population went unquestioned.

After World War II, Indian perceptions of reservations and cities began to change. The war showed many Indians a world they had never seen and seldom heard of. There were opportunities for achievement in the military service which they had never found on reservations. They proved themselves capable of using those opportunities and returned home with confident hopes that they could make their reservations better places to live. This hope soon turned to despair as they tackled the obstacles which impeded (and today still impede, as chapter 7) reservation development. Many Indians, however reluctant to leave their communities and families, decided that low quality subsistence was the only future for the reservations and set off for the cities to find work. By 1951, more than 17,000 Navajos

[1] Meriam, Lewis, The Problem of Indian Administration, "The Migrated Indians" ch. XII.

worked away from the reservation, primarily on railroads and agriculture.

At the same time, the Federal policy of assimilation manifested itself in a new way. A theory that reservations were overpopulated gained credence. By 1954, a congressional report entitled, "Survey Report on the BIA" generalized that "most of the reservations are overpopulated, and could not support the population at anything approaching a reasonably adequate standard of living."[7] Rather than pursuing a way to make Indian homelands financially secure places to live, the Federal Government chose to follow a simpler approach: relocation of Indians away from the reservations. Thinning out the population of reservations, however, did not solve the problem. The fact that Indians left the reservation did not mean they were willing to stop being Indians; and whether or not reservations bred some social problems, it could not have been assumed that those problems would be shed at the reservation boundaries. Nevertheless, Federal policy followed exactly that simplistic an approach. Transportation funds were provided, but relocation services were not.

The Federal Government not only failed to provide needed services to the Indians it relocated, but actually refused to provide those services. The Federal relocation program was to be initiated by the BIA but was left to be implemented by local, State and county assistance programs, or churches or humanitarian organizations. The only thing that was shrugged off at reservation boundaries, it turned out, was Federal responsibility.

Indians affected by relocation were not given an opportunity to tell their side of the story until the National Council on Indian Opportunity held hearings in five major cities in 1968 and 1969.[8] The numerous criticisms that were heard at this time fell into three categories: (1) The lack of orientation in relocating from reservations to cities; (2) the low quality of opportunities for work; (3) the confusion of where to turn for necessary services. Federal policy had ignored particular difficulties Indians faced in the cities, difficulties such as language barriers, questions of where to find services or help in emergencies, and the most fundamental problems of daily survival.

The special problems which Indians face when they are away from their reservations are another unique aspect of the Federal-Indian relationship. Whatever historical forces have contributed to these problems, it is apparent that the situation is significant enough to deserve Federal attention.

To solve these problems which the Federal Government largely created and then totally ignored, Indian people themselves have contributed the most recent and the most constructive development in the history of off-reservation Indians. That is the development of urban Indian service centers. Some of these centers have evolved from very small groups organized for recreational purposes into multifaceted operations capable of sustaining programs in educational and vocational training, defense of tenant rights against unscrupulous landlords, psychological and career counseling, various kinds of entertain-

[7] U.S. Congress, House Committee on Interior and Insular Affairs, "Survey Report on the Bureau of Indian Affairs," 1954, p. 23.
[8] National Council on Indian Opportunity, hearings in Los Angeles, Dallas, Minneapolis-St. Paul, San Francisco, and Phoenix, 1968–69.

ment, and the provision of emergency relief. There can be no doubt that today the Indian centers are a sound and creative response to the Indians' frustrations with their urban environment.

The urban Indian service centers have not, however, completely solved the problems urban Indians face. In fact, they have encountered many obstacles which the Federal Government could remove, and have clarified a new policy problem in the administration of Federal programs for urban Indians. There is a unique relationship between the Federal Government and urban Indians, both because of the uniqueness of the problems urban Indians face and because of the uniqueness of the historical factors which made some Indians urban residents. How to administer that unique relationship has not yet been determined. Instead of taking the initiative and providing services to these Indian people, the Government has chosen to argue over responsibility and jurisdiction; these arguments continue to the present day.

Policy and Law Relating to Off-Reservation Indians

The following discussion examines briefly the concept and scope of the Federal trust responsibility to off-reservation Indians.[9] The exclusion of nonreservation Indians from the Federal trust relationship does not follow from a careful legal analysis but rather emanates from perceived practical considerations and the attitude, "it has always been done that way."

While the Federal trust responsibility extends from the Federal Government directly to the tribe, it must be noted the tribe as an entity does not exist without its people. Thus, it can be said that the ultimate beneficiary of the trust is the individual Indian as a member of his tribe.[10]

This is obviously true, for example, when the Federal Government acts to protect an individual Indian's land from being taxed by the State.[11] It is also true, however, when action is taken to protect a tribe's water resources on the reservation.[12] Individual Indians, including most of those living in urban and other nonreservation areas, generally identify themselves in the context of their tribal affiliation.

Probably few, if any, Federal administrators or legislators would disagree with the above comments. Dissent increases, however, when it is suggested that the Federal Government's trust responsibility applies to tribal members living off the reservation as well as to those living on Indian lands. This dissent results partially from the fixed thinking predominant in government that the Indian trust equates with land and nothing more, and partially from the mistaken notion that if an Indian leaves his reservation, it is with a conscious understanding that he is putting his tribe behind and assimilating to non-Indian society. As the historical review points out, more often than not, individual Indians who chose to leave reservations did so because they could not find jobs, or decent housing, or a quality education there. Moreover, many were practically forced to leave by BIA insistence, and in this situation the Federal responsibility is certainly clear.

[9] See ch. 4 for a complete discussion of the Federal trust responsibility.
[10] See U.S. v. Holliday, 70 U.S. 407 (1865).
[11] E.g., Board of County Commissioners v. Seber, 318 U.S. 705 (1943).
[12] Winters v. U.S., 207 U.S. 564 (1908).

Most importantly, Federal policy should not be based on the Government's intention to dictate any group's culture. In discussing Indian policy, of course, this point becomes crucial. Assimilation has not succeeded and has largely been discarded. For urban Indians, however, there are many residual administrative obstacles which were constructed on the theory that off-reservation Indians gave up their tribal status, or should have given it up. The overwhelming majority of Indians in this country continue to be tribal members, regardless of where they live and regardless of whether or not their tribe is recognized by the Federal Government, and in spite of continuous policies aimed at destroying tribal society. The Federal Government's trust obligation to Indian tribes should extend to these tribal members as well as to their reservation brothers for there is no sound legal or political reason to discriminate against them.

No court, no general act of Congress, certainly no constitutional provision states that the Government's special responsibility to the Indian people stops at the reservation gate. The concept of trust responsibility is most often applied in the context of recognized reservation Indians, but several court decisions have found that the Government's legal duty is not so limited. For example, to benefit from the Federal responsibility to protect trust lands, the individual Indian need not reside on a reservation;[10] it makes no difference that he is a United States citizen as well as a tribal member, for "citizenship is not incompatible with tribal existence or continued guardianship."[11]

The unique need of nonreservation Indians has not been totally ignored in modern legislation,[12] but much of the intent of those Acts has been circumvented either by administrative neglect or outright refusal to provide services targeted to Indians.

Before 1921,[13] there had been no specific authorization for the appropriation and expenditure for most of the programs which the Bureau of Indian Affairs had come to maintain for the benefit of Indians. In the Congress, appropriations for the Bureau of Indian Affairs were subject to a point of order objection which frequently resulted in cumbersome and time-consuming maneuvering while Indian programs hung in suspense. This frustrating process was at least partially

[10] Heff v. U.S., 283 U.S. 848 (1931).
[11] U.S. v. Nice, 241 U.S. 591, 598 (1916).
[12] E.g., sec. 302 of the Comprehensive Employment and Training Act of 1973, 87 Stat. 839, makes nonreservation Indian groups and organizations eligible as prime sponsors in manpower programs.

Under the Native American Programs Act of 1974, 88 Stat. 2323, the Office of Native American Programs in the Department of Health, Education, and Welfare has the objective to provide direct support for self-determination programs aimed at improving the health, education, and welfare of Native Americans both on and off reservations. Legislative history of the Act suggests that Congress intended ONAP to expend the largest share of its budget on programs for nonreservation Indians. Analysis of ONAP grants, however, indicated that approximately 80 percent of its budget is going to reservations.

Public Law 93-638, passed on Jan. 4, 1975 (88 Stat. 2203) also includes nonreservation Indians as eligible contractors under the provisions of the Act by defining a tribal organization as any "recognized governing body of any Indian tribe" or "any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization . . ." sec. 4(c).

The recent passage of P.L. 94-437, title V, indicated the Federal Government's recognition of the urban Indian's health problem; however, rather than solving the problem, it highlights many of the complex issues surrounding urban Indian health care. As well as other issues, P.L. 94-437 highlights the following needs: (1) identification of all public and private health service resources within the urban center which may be available to urban Indians; (2) assistance of urban Indians in becoming familiar with and utilizing such resources; and (3) provision of basic health education to urban Indians.

[13] 25 U.S.C. 13.

relieved by passage of the Snyder Act which authorized items of appropriations in nine broad program areas:

> The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:
> General support and civilization, including education.
> For relief of distress and conservation of health.
> For extension, improvement, operation, and maintenance of existing Indian irrigation systems and for development of water supplies.
> For the enlargement, extension, improvement, and repair of the buildings and grounds of existing plants and projects.
> For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges and other employees.
> For the suppression of traffic in intoxicating liquor and deleterious drugs.
> And, for general and incidental expenses in connection with the administration of Indian Affairs.

A pertinent interpretation of the Act was made in December, 1971, by Assistant Solicitor for the Division of Indian Affairs, Department of the Interior, Charles Soller. In that written opinion to the Commissioner of Indian Affairs, Mr. Soller stated that: "On its face, the underscored language is abundantly clear and requires no interpretation. Literally, it authorizes the expenditure of funds for the purposes within the named program categories for the benefit of any and all Indians, of whatever degree, whether or not members of federally recognized tribes, and without regard to residence so long as they are within the United States * * *. With language so unequivocal, it is subject to the general rule of the law that plain and unambiguous statutory language will be followed * * *."[14] The opinion states that the Snyder Act will support a broader eligibility for Bureau services, but it cautions the Bureau against extending BIA services to all Indians without first considering other "statutory limitations"[15] and without first consulting with appropriate congressional committees. Apparently, however, the Bureau never got a chance to take those other two steps because the Commissioner received specific instruction from the then Assistant Secretary, Harrison Loesch, not to divert the Bureau's "attention and limited funds from our basic responsibility of serving on-reservation Indians."[16]

Not only was the rationale weak which the Assistant Secretary presented for this limitation of services, but the statement itself shows a lack of understanding. He apparently understood that no off-reservation Indians were receiving Bureau services, except in special hardship cases. But, as explained in considerable detail by the Supreme Court in *Morton* v. *Ruiz*, the provision of BIA services "clearly has not been limited to reservation Indians" only.[17] Native Americans in Oklahoma and Alaska have received and still are receiving certain services from the BIA, whether they reside on or off the reservation.

[14] U.S. Dept. of the Interior, Office of the Solicitor, Scope of the Snyder Act of Nov. 2, 1921, 42 Stat. 208, 25 U.S.C. sec. 13, memorandum of Commissioner of Indian Affairs from Assistant Solicitor (Indian Affairs), Dec. 9, 1971.
[15] Ibid.
[16] U.S. Dept. of the Interior, Office of the Assistant Secretary, Adherence to Our Long-Standing Policy of Not Providing Special Bureau of Indian Affairs Services to Off-Reservation Indians, Memorandum from Asst. Secretary for Public Land Management Harrison Loesch, to Commissioner of Indian Affairs, Jan. 16, 1970.
[17] 415 U.S. 199, 212 (1974). This is also true for services provided by the Indian Health Service.

The Indian relocation program and general assistance benefits connected with that program are extended to nonreservation Indians.[46] Special vocational training programs have long been made available to off-reservation Indians.[47] Educational services had similarly been extended to them by virtue of the Johnson-O'Malley Act.[48]

It is true that the Court in the *Rucs* case did not interpret the Snyder Act as *requiring* the Bureau to provide its social services program benefits to all Indians. But it is equally true that the decision interpreted the Snyder Act in broad enough terms so that such an application would be permissible. It stated that:

> We need not approach the issue in terms of whether Congress intended for all Indians, regardless of residence and of the degree of assimilation to be covered by the general assistance program. We need only ascertain the intent of Congress with respect to those Indian claimants in the case before us.[49]

Thus, the Court chose to avoid a definitive judgment on the overall issue by limiting its holding that the Bureau of Indian Affairs has the duty to provide general assistance services to Indians living "on or near the reservation" and who maintain close economic and social ties to the reservation. In spite of this requirement, BIA Manual still blatantly states that it limits eligibility to "on-reservation" Indians plus Oklahoma Indians and Alaskan Natives.[50]

The persistent refusal of the Bureau of Indian Affairs to address the problems of off-reservation Indians and to accept responsibility for fostering programs which will meet the needs of these Indian people, underscores a very basic discrepancy in the United States Indian policy.

The agent entrusted to carry out the trust which the United States assumes in its relationship to Indian people, should be eager to carry out that trust in whatever area it may encompass. To deny the rights of Urban Indians is to question the position of all Indians in United States policy. As Syd Bean, Executive Director of the Phoenix Indian Center testified at a Task Force Eight hearing, "if the off-reservation Indian communities are forced to terminate their rights for special Indian services then the Federal Indian relationship is threatened for all Indians." [51]

The Urban Environment and Urban Solution

Between the intentions of the lawmakers and the reality of representatives lies the service gap that confronts the urban Indian. The result is untold desperation and waste of human resources.

Most Indians who migrate to the cities say they would have preferred not to do so at all. Still, the census figures for the years 1960-1970 show a rate increase of from 20 to 45 percent, and an HEW report published in 1970 sheds some light on the reasons.[52] The report

[46] 25 U.S.C. sec. 471. *See Morton v. Ruiz*, 415 U.S. 199 (1974).
[47] *Morton v. Ruiz*, 415 U.S. 199 (1974).
[48] 25 U.S.C. sec. 452.
[49] 415 U.S. 199, 231 (1974).
[50] Indian Affairs Manual, sec. 9, 4. *See generally*, Y. Deloria, Jr., "Legislative Analysis of the Federal Role in Indian Education," contract for the Dept. of Health, Education and Welfare, 1972.
[51] Written testimony submitted by Syd Bean at a hearing conducted by Task Force Eight, Feb. 9, 1970, p. 14.
[52] "A study of Selected Socio-Economic Characteristics of Ethnic Minorities Based on the 1970 Census: vol. III, American Indians." Office of Special Concerns, Office of the Assistant Secretary for Planning and Evaluation, Dept. of HEW, 1974.

showed that the most apparent shift from reservation to city was among those of prime employment age, between 20 and 40. It also showed that older Indians—those beyond the age of peak employment—moved back to their reservation. The report concluded that the lack of job opportunities in rural and reservation areas lent impetus to the migration.

The survey and results of the hearings by Task Force Eight affirmed that most Indians move to urban areas with hopes for jobs or for finding better jobs than on the reservation and rural areas.[53]

Regrettably, this expectation has often remained for the most part unfulfilled. The HEW report suggests that low employment may be due to inadequate vocational training,[54] a conclusion supported by the Commission's finding in two areas. One is that educational facilities on reservations are limited in standard, and the reservation is where most Indians receive their education. The other is that Indians who are educated in programs initiated outside the BIA often find that the skills they learn are *not* salable, and that job placement activities are limited. To date, employment assistance has been geared toward placing Indians in low-paying, entry-level jobs, rather than orientation and training for positions that could lead to upward mobility.

It has only been in the last 5 years that the BIA has ostensibly changed their former "relocation" policies. The new thrust, announced by Commissioner Louis R. Bruce in 1972, was a policy advocating for the end of termination era programs. Some of the more imaginative uses of employment assistance funds has followed emphasizing on-reservation training for tribal economic programs. Unfortunately, this emphasis is too late for those Indians who have employment and social problems in the cities.

The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the service gap reveals itself again. Ineligible for Indian Health Service assistance because he is off the reservation, the urban Indian finds that other means of finding medical attention are closed off as well.

Non-Indian health service hospitals are often reluctant to admit Indian patients for fear they will not pay. Local welfare agencies and charitable organizations often have the same fear, compounded by a belief that all Indians are the responsibility of the Federal Government. These agencies already juggle funds and personnel to serve as many needs as possible and often deny Indians treatment entirely or serve them in a superficial way.

Yet, the urban Indian often has special problems requiring treatment that is costly, prolonged and, to be successful, must be based on understanding of complex sociological factors. Two examples are the high incidence of both alcoholism and drug abuse. Both leave the urban

[53] Response from 62 organizational questionnaires regarding the needs of urban Indians enumerative showed employment needs for the most frequently mentioned and respondents themselves unanimously mentioned this before any other.
[54] 1970 HEW report, p. 33.

Indian not only in wretched physical condition, but also in danger of social repercussions, jail, and repeated fines.

Few alternatives exist in the areas of housing. Urban Indians, unschooled in rents, mortgages, or leases because of their lives on the reservation, are often targets for unscrupulous and dishonest landlords. Lacking preparation, orientation, and money, the Indian often finds himself in overpriced, substandard housing located in marginal neighborhoods.

If he tries to ease the financial and emotional burdens by sharing living quarters with another family, the results are often unsatisfactory. Overcrowding and unhealthy living conditions are two immediate results, and harrassment from landlords is almost certain to follow. Families in particular often become discouraged at this point and return to the reservation, remaining only until resources are exhausted to try the cities once again.

This back-and-forth migration works to the Indian's disadvantage. The task of gathering information that will document the problem is difficult and programs that could be funded by grants are hard to justify. It also limits the experience of social welfare agencies with unique Indian problems. Thus it becomes hard for these agencies to become conversant with the specific problems and to assist Indians accordingly, even if funds and staff were available.

One solution has been proposed and tried, with some success. Until recently, the Snyder Act provided for equity grants to be used in making downpayments on homes. These grants were available to relocates who remained in the same city for 3 to 5 years. The programs was recently cut back, a casualty of economic pressures that have reduced funding for social service programs. Reinstituting it would be highly effective, particularly if it were extended to all Indians.

THE URBAN CENTERS

In this bleak picture, the only real source of help for city Indians has been the urban centers that grew spontaneously out of informal Indian community get-togethers. Indians who moved to cities found that they shared many of the attitudes and the problems of other urban Indians. Across tribal differences, they immediately established friendly ties with Indians who were already established in the cities and sought to help Indian newcomers as they moved into the cities. Eventually, this feeling of comradeship inspired the idea that Indians could help each other out if they organized Indian Community Centers. These centers called "urban centers" present a number of options for Indians facing the urban world. Unfortunately, the Federal Government has failed to recognize the significance and utility of these centers for administering, or assisting in, the implementation of Federal programs for urban Indians.

For newly arrived urban Indians, the center's first function is to provide emergency care. This care may range from provision of food and clothing to finding housing by tracking down relatives or keeping up with available apartment and home listings. After dealing with these emergencies, services run the gamut from education to health care to psychological assistance.

It should be emphasized that urban Indians have done much to add to the cultural diversity and richness of many of the communities in which they live. Many cities have become justifiably proud of the Native American population. As a matter of fact, cities like Los Angeles have set the pace with support of Mayor Tom Bradley and other city officials in advocating for their Indian residents. Since this is particularly a discussion of the rule rather than the exception, we must say that the city of Los Angeles is one of the rare exceptions.

The reader should not suppose that each urban area is serviced by a highly integrated and consolidated agency called an "Indian Center." In many locations, this is a recent effort. In others, Indian centers have existed and worked with many other Indian organizations for a number of years. As Thomas Greenwood, acting president of the Indian Health Service, Inc., of Chicago, Ill., stated in his comments on the American Policy Review Commission's tentative final report:

> In Chicago and probably in many other cities as well, a network of more than twenty Indian organizations services the total population. Several are very general and inclusive in the programs that they offer; others concentrate on specific issues * * *. The reasons for the multiplicity of organizations are complex—relating to administrative convenience, tribal divergence, certain peculiarities in traditional modes of organization and attitudes toward power, circumstances in funding, and accidents of history. It is not clear whether a single comprehensive agency handling Indian programs in a given city is feasible—or desirable. To designate "Indian Centers" as the recipient of funds without considering the question is simply to invite problems.

Suffice it to say, however, that the model center providing multiple services seems to be the most efficient and practical method of delivering assistance whether run by one Indian center board of directors or by a board of several participating organizations.

Centers in many cities have set up educational programs, organized job banks and given moral support to those seeking employment. However, efforts are impeded because there is no mechanism for coordination of BIA vocational training programs. Though urban centers keep up to date lists of job opportunities, this knowledge is not used as the basis for the BIA vocational training program. Thus the BIA may train welders in cities offering opportunities for computer programers. Indians themselves have organized more innovative approaches to finding jobs in the city.

The Bureau of Indian Affairs continues to support Employment Assistance Offices in most cities with large Indian populations. Yet, these offices do not work with "unofficial" urban centers which are the point of contact for most Indians seeking work. BIA Employment Assistance is one of the most needed services for urban Indians, but ironically most urban Indians do not meet eligibility requirements. It is extremely unfortunate in that Federal programs neglect to use grassroots solutions to this problem.

The most difficult off-reservation service is health care. Physical requirements for facilities and fiscal requirements for personnel make it difficult for the urban center to attempt primary care, let alone the specialized therapeutic services that Indians need. Though Public Law 94-437, title V indicated the Government's recognition of the problem, it set up criteria for assistance that are difficult to fulfill.

The law states that an urban center must "determine the Indian population which are or could be recipients of health referral or care services . . ." and "identify gaps between unmet health needs of urban Indians and the resources available to meet such needs." The problem, of course, is the migratory patterns of urban Indians who, defeated by the lack of opportunities available to them in either reservations or cities, often move back and forth from reservation to urban centers. Because population determinations are the basis upon which aid is provided, urban Indians are once again shortchanged.

NEW COMMUNITIES AND CONTINUING SERVICES IN NEW ENVIRONMENTS

Perhaps the most important contribution of the urban centers to the Indian living in cities has been a psychological one. Having left the tribal community, and often, their families, Indians feel isolation and loneliness. They developed these centers as places where such needs are partly satisfied and where they can join together in social gatherings that substitute for the personal security of the reservation. Some of the centers have evolved from very small groups organized for recreational purposes into multifaceted operations capable of sustaining programs in education and vocational training, defense of tenant rights against unscrupulous landlords, counseling, various kinds of entertainment and the provision of emergency relief. There can be no doubt that these Indian service and cultural organizations are a firmly based and creative response to Indian problems.

The Indian service centers present an ambitious range of services and objectives.

Unfortunately, they must rely on donations and volunteer work. Moreover, leaders who operate these centers are often volunteers and usually overworked. They serve out of a feeling of responsibility to the Indian community. While this is one of the dynamic and inspiring aspects of the development of urban centers, it has an unfortunate long-term effect in that there are necessarily frequent changes in leadership. While individual centers may expand or collapse, it is important to realize that the majority of urban centers have provided, and are continuing to provide, valuable services to people who are inadequately assisted through other channels. Moreover, they provide these services without usurping the relationship of the individual Indian to his tribe. The centers strengthen the urban Indian's ties to his cultural heritage by providing necessary facilities and services within an Indian setting. These organizations reinforce, rather than destroy, Indians' identification with their tribes and their heritage.

Because of the broadbased, highly sensitive services these urban centers provide, the Commission believes that their role in assisting Indians should be strengthened with trained staff and money. The Federal Government should realize that urban centers, created seperately and directed by Indians themselves, are an effective instrument for reaching the Government's goals of assisting urban Indians.

Indian centers suffer from a lack of management information and procedural standards. Like their reservation-based counterparts, tribal governments, they are often expected to know the rules when they do

not have them and to live up to unexplained standards. Provision of data on ways to effectively organize and manage the delivery of human services would be of great assistance in enriching the role for urban centers.

Fiscal and management assistance is necessary if these centers are to provide the kind of service that will enable their people to live productive lives. This assistance should be administered in several ways.

In employment, the most expedient way to provide assistance is to build on the philosophy of Indians operating Indian programs. This would entail turning over BIA Employment Assistance Offices and their programs to urban centers.

Furthermore, it would provide an administrative base necessary for an urban assistance program. Administration could be carried out by existing urban Indian centers in close cooperation with tribal governments.

The Commission devoted a great deal of time to studying this alternative. Part of the study involved contacting urban center directors. While many directors felt the centers could administer funds the best, they acknowledged that tribal governments should also play an important role. As these governments stabilize politically and economically, they could be practical mechanisms for managing funds for their own membership.

Many programs now directly administered by Federal, State, or local governments are often contracted out to private or public organizations. These are contract awards for urban services which would not be otherwise allocated to Indian tribes. Urban Indian organizations, however, are frequently discriminated against in these kinds of situations, and private non-Indian contractors benefit from contract opportunities which should properly be delegated to Indian professional people. Indian service centers, once given the opportunity and clear identification of the obligations that go with it, are very capable of hiring professionally qualified personnel.

RECOMMENDATIONS

The Commission recommends that:

1. The executive branch of the Federal Government conduct a detailed examination of assistance programs and need areas that would be most expeditiously administered by tribal governments.

2. The executive branch provide for the delivery of services to off-reservation Indians consistent with the Federal obligation to all Indians. Accordingly, Congress recommend that the executive branch deliver appropriate services when feasible through urban Indian centers.

URBAN CENTERS

3. The executive branch provide financial support for Indian centers in urban areas. This could be expedited by turning over BIA Employment Assistance Offices and other Federal contracting opportunities to urban service centers; and delegating Federal domestic assistance funds directly to urban centers on a fair per capita share basis.

4. The executive branch consider the placement of Federal fun
targeted for urban Indians under an Urban Indian Office as a po
of their considerations for the Consolidated Independent India
Agency.

5. The Federal agency funding such urban center or centers dete
mine the actual representation of such center or centers according
a process of membership certified to the agency.

EDUCATION

6. The executive branch mandate that urban centers receive:

Specific consideration for the receipt of Johnson-O'Malle
funds;

Technical assistance and orientation in programing, budgetin
regulations, and funding programs;

Specific roles in program and policy formation in curriculu
development for teaching and administrative staff hiring f
schools with Indian children;

Funding for administrative and program costs.

HOUSING

8. The executive branch mandate that urban Indian centers be su
ported to provide: **

A real estate clearinghouse to provide information on availab
living quarters;

Consumer education programs in the areas of credit procedur
lease information, and general advice on moving from the res
vation to an urban area;

Grants for initial moving costs, immediate support, rent su
plements, housing improvements; and

The Bureau of Indian Affairs reestablish the program formerl
funded providing equity grants for downpayments to urban In
dians who have lived in the city for more than 2 years.

HEALTH

9. The executive branch mandate that appropriate action be tak
to provide urban Indians with health care facilities by providing t
urban Indian center with funds to:

Administer Indian health care programs;

Provide information for health care;

Contract for Indian health care;

Establish health educational programs;

Establish health care programs on its premises; and

Act as a monitor for funds designated for urban Indian heal
care.

** These funds are presently provided to the Bureau of Indian Affairs for the s
purpose.

Exhibit D

Health Status of Urban American Indians and Alaska Natives

A Population-Based Study

David C. Grossman, MD, MPH; James W. Krieger, MD, MPH; Jonathan R. Sugarman, MD, MPH; Ralph A. Forquera, MPH

Objective.—To use vital statistics and communicable disease reports to characterize the health status of an urban American Indian and Alaska Native (AI/AN) population and compare it with urban whites and African Americans and with AI/ANs living on or near rural reservations.

Design.—Descriptive analysis of routinely reported data.

Setting.—One metropolitan county and seven rural counties with reservation land in Washington State.

Subjects.—All reported births, deaths, and cases of selected communicable diseases occurring in the eight counties from 1981 through 1990.

Main Outcome Measures.—Low birth weight, infant mortality, and prevalence of risk factors for poor birth outcomes; age-specific and cause-specific mortality; rates of reported hepatitis A and hepatitis B, tuberculosis, and sexually transmitted diseases.

Results.—Urban AI/ANs had a much higher rate of low birth weight compared with urban whites and rural AI/ANs and had a higher rate of infant mortality than urban whites. During the 10 years, urban AI/AN infant mortality rates increased from 9.6 per 1000 live births to 18.6 per 1000 live births compared with no trend among the other populations. Compared with rural AI/AN mothers, urban AI/AN mothers were 50% more likely to receive late or no prenatal care during pregnancy. Relative to urban whites, urban AI/AN risk factors for poor birth outcomes (delayed prenatal care, adolescent age, and use of tobacco and alcohol) were more common and closely resembled the prevalence among the African-American population except for a higher rate of alcohol use among AI/ANs. Compared with urban whites, urban AI/AN mortality rates were higher in every age group except the elderly. Differences between urban whites and AI/ANs were largest for injury- and alcohol-related deaths. All-cause mortality was lower among urban AI/ANs compared with rural AI/ANs and urban African Americans, although injury- and alcohol-related deaths were higher for AI/ANs. All communicable diseases studied were significantly ($P<.05$) more common among urban AI/ANs compared with whites. Tuberculosis rates were highest in the urban AI/AN group, but rates of sexually transmitted diseases were intermediate between urban whites and African Americans.

Conclusions.—In this urban area, great disparities exist between the health of AI/ANs and whites across almost every health dimension we measured. No consistent pattern was found in the comparison of health indicators between urban and rural AI/ANs, though rural AI/ANs had lower rates of low birth weight and higher rates of timely prenatal care use. The poor health status of urban AI/AN people requires greater attention from federal, state, and local health authorities.

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IT IS generally known that the health status of American Indians and Alaska Natives (AI/ANs) is far below that of other Americans.[1] However, this conclusion is based on statistical reports from the Indian Health Service (IHS), an agency of the Public Health Service, and tribally owned health programs on or near Indian reservations or Alaska Native lands. Little is known about the health status of urban AI/ANs despite the fact that 56% of the AI/ANs identified in the 1990 US Census now reside in urban areas.[2] The IHS was created by Congress and is currently directed to "assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy."[3] Congress recently established health status objectives specifically for AI/ANs that are to be accomplished by the year 2000.[3] Funding and politics have restricted most IHS activities to tribal members living on or near Indian reservations or Alaska Native lands.

Very little health information is available regarding AI/ANs in urban areas.[4] Most published studies of urban Indian health are based on data from clinics and hospitals and cannot be generalized to an entire urban AI/AN population.[5] In a comprehensive report on Indian health published in 1986, the Office of Technology Assessment concluded that "the IHS does not collect diagnostic patient care information from urban programs and does not analyze or publish vital statistics or population characteristics for urban AI/ANs except when these data are included with national level data on the reservation states."[4] Since the publication of this report, there have not been any large population-based studies that broadly describe the health status of any urban Indian population.

The purpose of this study was to use available vital statistics and health data to characterize the health status of the AI/AN population in the largest metropolitan county within the state of Wash-

ington and to compare its health status with three reference populations. The comparison populations are the white and African-American populations within the same metropolitan county and the AI/AN population living in rural Washington counties with tribal reservations.

METHODS

Site

According to the 1990 US Census, the Seattle, Wash, metropolitan area has the seventh largest concentration of urban AI/ANs in the United States. King County, Washington, is a large metropolitan region with a population of 1 507 319.[5] There are three cities with more than 50 000 residents, the largest of which is Seattle. The 17 305 AI/AN residents comprise 1.1% of the King County population and 21% of the state's AI/AN population. Of the King County AI/AN residents, 1461 (8.4%) reported that they were of Eskimo or Aleut ancestry on the census. Data sets from which numerator data were derived do not allow stratification of Alaska Natives from American Indians. Within King County, there is one small reservation with a tribally operated clinic. The Seattle Indian Health Board, one of 34 nonprofit organizations partially funded by the IHS, operates a comprehensive community-based primary care program that cares for AI/ANs.

Comparison Groups

First, we compared the health status of AI/ANs with that of whites and African Americans within King County. Second, we compared health status indicators of the King County AI/ANs ("urban" AI/ANs) with those of AI/AN residents of rural Washington counties with tribal reservations, a population traditionally served by the IHS. These seven counties are classified by the Washington State Department of Health as "rural" (15 to 100 persons per square mile) or "remote rural" (<15 persons per square mile) counties and have reservation land belonging to federally recognized tribes. King County and the rural reservation counties account for 40% of the state's total AI/AN population. The remainder of the state's AI/AN residents live in other urban/metropolitan counties or rural counties without reservations.

Data Sources

Three main data sources were used to generate numerator data for vital statistics rate calculations. These included birth certificates, linked infant birth and death certificates, and death certificates from 1981 through 1990 from the Center for Health Statistics of the Washington State Department of Health. Communicable disease data were obtained from the Centers for Disease Control and Prevention and the Epidemiology Office of the Washington State Department of Health. Data from the 1980 and 1990 editions of the US Census provided the denominator and socioeconomic data for each of the comparison groups. Population estimates for urban and rural AI/ANs between 1980 and 1990 were generated by linear interpolation between 1980 and 1990 US Census counts while estimates for urban whites and African Americans were based on Washington Office of Financial Management demographic estimates. These Office of Financial Management estimates were unavailable for all counties in the study, so all AI/AN denominator estimates were derived using linear interpolation. The differences between the two denominator estimates (for the intercensus period) were quite small. The interpolation method gave a slightly higher number for each of the years, with a range of ratios from 1.02 to 1.06. This method consistently exceeded the Office of Financial Management estimate and resulted in a probable underestimate of mortality rates of urban AI/AN residents compared with other races.

We used the post-1989 National Center for Health Statistics definition of race for all infant birth and death rate calculations in the study. The National Center for Health Statistics currently defines an AI/AN birth as an infant born to a mother identified in the birth record as AI/AN, regardless of the father's race. We used linked birth and death certificates for infants in which the mother's race at birth defines the race at birth and death. Individuals self-report their race to the US Census.

Table 1.—Demographic Characteristics of Study Populations

Characteristic	Urban			Rural
	AI/AN*	White	African American	AI/AN
1990 population	17 305	1 388 339	73 483	[illegible]
Older than 25 years without high school diploma, %	24	10	21	24
Unemployed, %	8.4	3.7	11.3	21
Below 100% of federal poverty level, %	28	8.1	22	26

*AI/AN indicates American Indian and Alaska Native.

Health Status Measures

The health status indicators used in this study were derived from routinely collected population-based health status data for which race-specific information was available. Mortality rate calculations included infant mortality, age-specific mortality rates in six age groups, cause-specific mortality, and alcohol-associated mortality. To assess alcohol-associated mortality, alcohol-related disease impact software was used.[7] This methodology, developed by the Centers for Disease Control and Prevention, uses the attributable risk from alcohol use for each cause of death to derive a composite rate of alcohol-associated mortality.

Maternal and infant health measures included the proportion at birth of preterm births (<37 weeks' gestational age), of low (<2500 g) and very low (<1500 g) birth weight, of unmarried mothers, of mothers who started prenatal care in the first trimester (on time care) or who had late (third trimester) or no prenatal care, and of mothers who smoked tobacco or consumed alcohol during pregnancy, and the school-age (ages 10 through 17 years) fertility rate. The data source for information on smoking and alcohol use during pregnancy and prenatal care was the birth certificate. Smoking data from 1986 through 1988 were used (question wording on Washington State birth certificates was changed in 1989). Assessment of alcohol consumption was added to the birth certificate in 1989. Maternal drug-use data are not routinely collected on Washington State birth certificates.

Because the AI/AN population is small, only reportable communicable diseases of high frequency were compared. These included sexually transmitted diseases (gonorrhea, syphilis, and chlamydia), tuberculosis, and hepatitis A and hepatitis B. Because detailed data for sexually transmitted diseases were unavailable for rural counties, these data were used for comparisons within King County only.

We used the following *International Classification of Diseases*[8] codes as definitions for cause-specific mortality: heart disease, 391 through 392.0, 393 through 398, 402, 404, 410 through 416, 420-429; cancer, 140-208; unintentional injury, E800 through E949; liver disease, 571; cerebrovascular disease, 430 through 434, 436-438; pneumonia and influenza, 480 through 487; homicide, E960-E969; diabetes, 250; chronic obstructive pulmonary disease, 491, 492, 496; suicide, E950 through E959; and all firearms, E922, E955.0 through E955.4, E965.0 through 965.4, E870, E985.0 through E985.4.

All disease and death rates were age-adjusted to the 1940 US population for

Table 2.—Prevalence of Risk Factors for Poor Birth Outcomes Among Urban American Indians and Alaska Natives (AI/ANs) Compared With Other Races and Rural AI/ANs

	Average Rates 1988 Through 1990 (Total Births)*			
	Urban			
Risk Factors	AI/AN (n=804)	White (n=22 201)	African American (n=1150)	Rural AI/AN (n=1061)
Low birth weight (<2500 g)	6.8 (7.7-11.8)	5.0 (4.8-5.2)†	13.0 (12.0-14.1)†	8.6 (4.3-7.2)†
Very low birth weight (<1500 g)	1.8 (1.0-2.7)	0.8 (0.7-0.8)†	2.8 (2.4-3.4)	0.8 (.30-1.7)
Preterm births (<37 wk gestation)	15.9 (13.5-18.6)	8.1 (7.9-8.4)†	17.7 (16.5-19.1)	13.0 (10.8-15.5)
Mother 10-17 y of age	9.1 (7.4-11.1)	1.7 (1.6-1.8)†	9.8 (9.0-10.8)	10.2 (8.5-12.2)
Single mother	89.1 (86.0-92.1)	15.7 (15.4-16.0)†	66.1 (63.6-68.5)†	64.6 (61.8-67.3)
Consumed alcohol‡	20.1 (16.3-24.4)	6.2 (5.9-6.5)†	11.0 (9.5-12.7)†	16.3 (13.5-19.3)
Smoker‡	36.2 (34.7-41.7)	20.0 (19.7-20.4)†	32.5 (31.9-36.0)	40.6 (37.5-43.6)
Received first-trimester prenatal care	66.5 (63.1-60.0)	83.9 (83.6-84.2)†	59.2 (57.5-60.8)	64.0 (61.0-67.0)†
Received late or no prenatal care	15.9 (13.5-18.5)	3.4 (3.3-3.6)†	12.7 (11.6-13.9)	10.0 (8.3-12.0)†

*Data expressed as percentage (95% confidence interval). Infant race determined by mother's race on birth certificate. Urban AI/ANs are the reference group for all statistical comparisons.
†Significantly ($P<.05$) different from urban AI/AN rate.
‡Two-year average rates, 1989 through 1990.
§Three-year average rates, 1988 through 1990.

two reasons. A recent Centers for Disease Control and Prevention conference on age adjustment concluded that the 1940 US population would continue to be recommended by the National Center for Health Statistics as the standard population for US mortality data (primarily for purposes of comparability to historical national data).[9] Also, IHS uses the 1940 population as the reference in its annual statistical publications, widely cited sources for AI/AN health data; thus, use of the 1940 population will facilitate comparisons. Confidence intervals (CIs) for age-adjusted rates were compiled using the method of Chiang,[10] and CIs for proportional rates were calculated by the method of Fleiss.[11] Three- or 5-year rolling averages were used to assess trends, depending on the frequency of the outcome. Chi-square test for trend was used to determine the statistical significance of rate trends over time.

To determine whether the difference in low-birth-weight rates between urban and rural AI/AN populations could be entirely explained by differences in known behavioral and biologic risk factors, we conducted a logistic regression analysis to determine the model that best explained low-birth-weight variation. The outcome variable was defined as the presence or absence of low birth weight. The main independent variable was whether the birth occurred in an urban or rural location. The covariates included known maternal risk factors for low birth weight, including smoking, alcohol use, adolescent age, prior pregnancies, and the interpregnancy interval.

RESULTS

Socioeconomic Characteristics

Data from the 1990 US Census revealed that, compared with whites, the urban AI/AN population had fewer high school graduates and higher rates of unemployment and poverty (Table 1). However, rural AI/ANs appeared to be the most disadvantaged group in the study. A third of those older than 25 years living in rural counties were without a high school diploma. Unemployment (21%) and poverty rates (35%) were also highest among rural AI/ANs.

Birth Outcomes

The prevalence of low birth weight (<2500 g) was considerably higher among urban AI/ANs compared with urban whites and rural AI/ANs, but was lower than the rate of low birth weight among urban African Americans (Table 2). The prevalence of very low-birth-weight (<1500 g) births and premature deliveries shared similar patterns, although only the differences between urban AI/ANs and whites were significant.

Using low birth weight as the dependent variable and urban or rural status as the main independent variable, we found that after adjustment for the interval between births, history of prior pregnancy, adolescent age, use of prenatal care, and maternal smoking, the difference in low-birth-weight risk between the rural and urban groups was no longer statistically significant (odds ratio, 0.90; 95% CI, 0.56 to 1.4; $P=.66$). Thus, it appeared that most of the variation was attributable to differences in risk profiles of each group and not to a community risk or protective factor represented by the urban/rural variable.

Like low birth weight, the infant mortality rate averaged over 10 years was 80% higher among urban AI/ANs than among whites (Table 3). Neonatal and postneonatal mortality rates were higher among the urban AI/ANs (data not shown). Infant mortality rates among the urban AI/ANs were not significantly different than those among African Americans or the rural AI/ANs.

A significant increase in the urban AI/AN infant mortality rate occurred during the decade starting in 1981 (Figure). Five-year rolling average rates increased consistently every 5-year period from 9.6 per 1000 live births during 1981 through 1985 to 18.6 per 1000 during 1986 through 1990 (χ^2 test for trend, 5.1; $P<.05$). This decade-long trend was not evident among the other county residents or the rural population. The apparent upward trend among African Americans was not significant.

Prenatal Risk Factors for Poor Birth Outcomes

Rural and urban AI/AN mothers shared a similar prenatal risk profile (adolescent age, single marital status, and use of tobacco and alcohol during pregnancy) for poor birth outcomes (Table 2). However, urban AI/AN women were less likely than rural AI/AN women to initiate prenatal care in the first trimester (56.5% vs 64.0%; $P<.05$) and more likely to have late (third trimester) or no prenatal care (15.9% vs 10.0%; $P<.05$).

Urban AI/AN mothers had a much higher risk profile in comparison with urban white mothers (Table 2). Births among mothers aged 10 to 17 years, mothers who were single, or mothers who used tobacco or alcohol during pregnancy were all more common among AI/ANs. Similarly, the lower rates of first trimester prenatal care and high rates of late (third trimester) or no prenatal care seemed to place AI/ANs at higher risk of poor birth outcomes. This risk profile closely resembled that of African-American mothers across all variables except for prenatal alcohol consumption, where the risk among AI/ANs was significantly higher.

Table 3.—Urban American Indians and Alaska Natives (AI/ANs) Mortality Rates Compared With Other Races and Rural AI/ANs by Age Group and Cause, 1991 Through 1995*

Mortality Rate	Urban			
	AI/AN	White	African American	Rural AI/AN
Infant (age 0-1 y), 10-y average rate, per 1000 live births (95% CI)†	14.7 (10.8-80.3)	8.0 (7.8-8.4)‡	17.5 (16.3-80.8)	23.2 (18.4-29.2)
Age-specific, y, 10-y average rate per 100 000 population (95% CI)				
1-14	88 (35-67)	39 (38.4-31.2)‡	39 (29.8-48.7)	62 (42-82)
15-24	162 (121-217)	83 (78.4-86.8)‡	131 (111.2-153.8)	205 (209-937)
25-44	235 (209-308)	127 (123.8-130.8)‡	279 (258.1-302.1)	388 (327-484)
45-64	1122 (963-1299)	693 (682.4-703.8)‡	1303 (1231.8-1378.8)	1092 (900-1294)
65-99	3099 (2805-3672)	4048 (4012.4-4084.8)‡	5188 (4951.3-5373.3)‡	5134 (4650-5643)‡
Total deaths	727	93 048	4525	821
Cause-specific, 10-y age-adjusted (to 1940) rate per 100 000 population (95% CI)				
All causes	597 (557-636)	473 (468.4-478.8)‡	728 (710.5-748.3)‡	747 (702-791)‡
Alcohol related	149 . . .	82 . . .	105 . . .	182 . . .
Heart disease	141 (120-163)	139 (137.1-140.3)	207 (195.8-217.8)‡	188 (164-212)‡
Cancer	76 (57-92)	127 (124.8-128.7)‡	175 (164.4-185.3)‡	93 (75-110)
Unintentional injury	68 (56-83)	29 (27.8-29.5)‡	36 (34.8-44.4)‡	116 (99-136)‡
Liver disease	50 (37-62)	9 (8.3-9.4)‡	15 (12.0-18.7)‡	44 (31-56)
Cerebrovascular	26 (19-35)	29 (27.7-29.1)	46 (42.5-53.1)‡	56 (42-70)‡
Pneumonia and influenza	22 (14-31)	12 (12.0-12.8)‡	13 (10.2-15.7)	15 (9-22)
Homicide	21 (14-28)	4 (3.8-4.5)‡	30 (25.7-34.0)	20 (12-27)
Diabetes	19 (11-27)	8 (7.8-8.7)‡	30 (25.4-34.3)	20 (12-29)
Chronic obstructive pulmonary disease	16 (10-26)	19 (18.5-19.8)	19 (15.1-22.1)	24 (15-33)
Suicide	17 (10-23)	14 (12.8-14.1)	9 (6.8-11.4)	26 (18-35)
All firearms	15 (9-21)	8 (7.9-8.8)‡	21 (17.3-24.2)	34 (24-45)‡

*CI indicates confidence interval. Ellipses indicate data not available.
†Based on linked birth and death files where mother's race is AI/AN.
‡Significantly different from urban AI/AN rate.

Age-Specific Mortality

Urban AI/AN age-specific mortality rates were higher in almost every age group compared with urban whites. The only exception was among the elderly (older than 65 years), in which the AI/AN rates were lower (relative risk [RR], 0.65; 95% CI, 0.56 to 0.75). The biggest difference was evident in the 25- to 44-year age group, though rates in the 1- to 14-year and 15- to 24-year age groups were nearly twofold higher than among whites. The only significant ($P<.05$) difference between urban AI/ANs and African Americans was in the oldest age group, in which rates for African Americans were higher.

Similarly, a comparison of death rates between urban and rural AI/ANs appeared to demonstrate slightly lower rates among urban AI/AN residents, although only the difference among the elderly (older than 65 years) reached statistical significance (RR, 0.60; 95% CI, 0.51 to 0.72; $P<.05$).

Cause-Specific Mortality

The overall age-adjusted mortality rate among urban AI/ANs was higher compared with whites, but lower compared with African Americans and rural AI/ANs (Table 3). Injuries and alcohol-related deaths accounted for the majority of excess mortality among AI/ANs. Urban AI/ANs had significantly ($P<.05$) lower age-adjusted all-cause mortality rates than rural AI/ANs as well as for heart disease, unintentional injury, cerebrovascular disease, and firearm injury. Rates for other specific causes of death (cancer, liver disease, pneumonia and influenza, homicide, suicide, diabetes, and chronic obstructive pulmonary disease) were not significantly different between the groups.

Within the urban county, the most striking differences in cause-specific mortality rates between AI/ANs and whites were for chronic liver disease and cirrhosis, unintentional injury, and homicide. Of the leading causes, only cancer was lower in the AI/ANs compared with whites. Compared with African Americans, the urban AI/ANs had lower all-cause death rates and lower rates from heart disease, cancer, and cerebrovascular disease, but higher death rates from unintentional injury and liver disease.

Communicable Diseases

Among communicable diseases, the prevalence of reported hepatitis A and hepatitis B was higher among urban AI/ANs than among rural AI/ANs, urban whites, and African Americans (Table 4). Similarly, urban AI/ANs also experienced a much higher reported prevalence of tuberculosis compared with all three other population groups. Reported prevalence rates of chlamydia, syphilis, and gonorrhea were much higher among urban AI/ANs compared with urban whites, but considerably lower than rates among urban African Americans. Race-specific rates of sexually transmitted disease were not available for rural AI/ANs.

COMMENT

The findings of this study confirm the existence of great disparities between the health of AI/ANs and whites living in one large metropolitan area. Urban AI/ANs have poorer health across almost every indicator we examined. The gap appears across almost all age groups and most causes of death. Many of the indicators were similar to those among urban African Americans, a group whose health status has repeatedly demonstrated the health inequities between whites and minorities in the United States.[18]

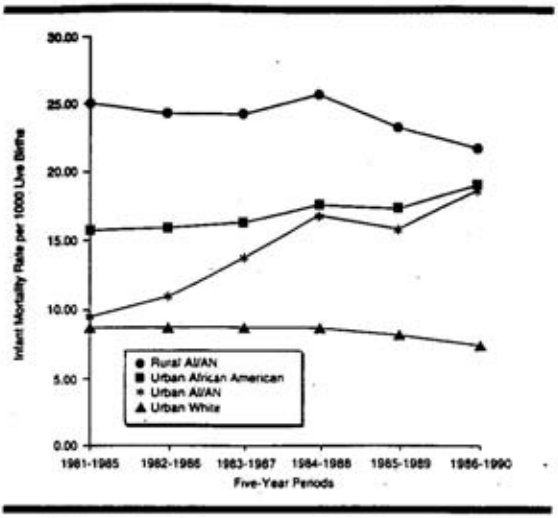
Our systematic comparison of health status indicators between urban and rural AI/ANs did not reveal a consistent pattern. Our most disturbing finding was the significant decade-long rise of the urban AI/AN infant mortality rate, a trend not shared by any of the other study populations. Rural AI/AN moth-

ers of newborn infants were more likely to have early and adequate prenatal care and were less likely to deliver a low-birth-weight infant than urban AI/AN mothers. This may be a result of access to comprehensive maternal and child health services offered by the IHS that include extensive public health nursing outreach systems. Access to these services in the rural IHS clinics may have led to earlier initiation of and follow-up with prenatal care. Though the earlier use of prenatal care and the lower rate of low birth weight appeared to demonstrate better maternal and infant health in the rural population, rural AI/AN infant mortality (including both neonatal and postneonatal mortality) was not lower in the rural counties. This surprising relationship between low birth weight and infant mortality rates may be a reflection of superior access to neonatal intensive care in the urban county.

The AI/AN mortality rates tended to be higher within the rural counties than within the urban area. The most striking age-specific difference was among the population older than 65 years. The higher rate of unintentional injury fatalities is not surprising since the incidence of fatal motor vehicle crashes is known to be higher in rural areas, especially among AI/ANs.[13] Almost all of the overall mortality difference can be explained by higher rates of the four leading causes of death (heart disease, cancer, injury, and cerebrovascular disease) among rural AI/ANs, compared with their urban counterparts.

Several limitations may have affected the results of this study. Although undercounting of AI/ANs in the census would have the effect of inappropriately increasing morbidity and mortality rates when the census population is used as the denominator, data from the 1980 and 1990 censuses suggest that the problem of undercounting of AI/ANs has diminished in comparison with earlier censuses.[14] Misclassification of race in vital records can result in substantial underestimates of mortality rates among AI/ANs.[15-17] We estimate that this differential misclassification affects mortality data by artificially minimizing some of the true disparity between whites and urban AI/ANs, ie, a conservative bias. We attempted to minimize the effects of racial misclassification for infant mortality rates and the prevalence of birth risk factors by using linked birth and death certificates and the current National Center for Health Statistics designation of race. However, estimates of AI/AN mortality rates for ages beyond infancy were not derived from linked files, raising the potential for significant racial misclassification and underestimation of the AI/AN rates. If misclassification of AI/ANs as other races was less likely to occur in rural areas (perhaps because morticians and coroners are more sensitive to the presence of a large AI/AN population), then urban rates would be selectively underestimated, thus accounting for some of the differences between urban and rural AI/ANs observed in this study. Indeed, in a study of racial misclassification of clients of the Seattle Indian Health Board, almost one third of persons who identified themselves as AI/AN to the clinic while living were classified as other races on death certificates, compared with approximately 12% inconsistent classification among primarily rural, IHS-registered AI/ANs in Washington.[18] Because the direction of this potential bias is known, study conclusions or policy implications should not be significantly affected. Data from birth certificates may be less susceptible to this potential bias.

In addition to racial misclassification on vital records, several studies in the Pacific Northwest have shown that morbidity rates calculated from registries of cancer,[19] AIDS,[20] end-stage renal dis-



Five-year rolling averages for infant mortality trends of urban American Indians and Alaska Natives (AI/ANs) compared with other races and rural AI/ANs. Data derived from linked birth and death certificates. Race classified according to maternal race.

Table 4.—Incidence of Communicable Diseases Among Urban American Indians and Alaska Natives (AI/ANs) Compared With Other Races and Rural AI/ANs

Disease	Urban			Rural AI/AN
	AI/AN	White	African American	
Hepatitis A†	151 (123-178)	42.0 (39.8-44.1)‡	43.4 (34.9-52.0)‡	106 (85-128)
Hepatitis B†	47 (31-63)	10.8 (9.7-11.8)‡	25.3 (18.8-31.8)	25 (14-35)
Tuberculosis§	60 (47-74)	3.0 (2.7-3.3)‡	16.8 (13.5-20.0)‡	20 (12-28)‡
Sexually transmitted diseases‖				
Chlamydia	516 (460-573)	255.5 (250.0-261.1)‡	1472.8 (1432.9-1512.2)‡	NA
Gonorrhea	298 (253-342)	81.0 (77.9-84.2)‡	2055.5 (2008.5-2102.5)‡	NA
Syphilis	47 (28-66)	4.9 (4.2-5.5)‡	183.7 (166.0-201.4)	NA

*All rates age-adjusted to 1940 US population. NA indicates not available. Data expressed as mean rates per 100 000 population (95% confidence intervals).
†Average rate, 1987 through 1990.
‡Significantly (P<.05) different from urban AI/AN rate.
§Ten-year average rate, 1981 through 1990.
‖Three-year average rate, 1988 through 1990.

ease,[20] and injury[21] may be underestimated among AI/ANs because of racial misclassification. Reporting bias is another potential concern in this study, primarily in the rates of communicable diseases. Care providers in the public sector, where indigent patients are more likely to seek care, may be more likely to report cases of communicable diseases to health authorities than private practitioners. The effect of this bias would be to overestimate the differences noted between whites and urban AI/ANs with respect to communicable diseases such as gonorrhea.

Should urban AI/ANs receive attention as a population with special health needs? More than half of AI/ANs now live in urban areas, but only a few of these areas, such as Albuquerque, NM, Phoenix, Ariz, and Anchorage, Alaska, offer direct IHS services. Title V of the Indian Care Improvement Act of 1976 was the first federal government recognition of the health needs of urban AI/ANs. Despite this recognition, few resources have been allocated to address these needs. The initial 1976 authorization called for a $15 million allocation for urban Indian communities to organize programs to "facilitate access to and, when necessary, provide health services to urban Indian residents."[22] In 1992, only $17 million was appropriated to urban Indian programs in cities where an IHS facility was not present, representing 1% of the total IHS budget. Because eligibility for the full scope of IHS services has been reserved for "persons of descent belonging to the Indian community served by the local facilities and program," it effectively excludes rural AI/AN residents who move to an urban area without an IHS direct care facility, perhaps in search of employment or family reunification.[5] Though the reasons for the presence of large urban AI/AN populations are not completely known, many urban AI/AN residents were coercively relocated from reservations by the federal government to the cities during a period in the 1950s known as the "termination era" in the history of relations between US Indians and whites.[23] This relocation policy separated AI/AN people from tribal land and culture, exposing them to the harsh social and economic conditions of the urban poor. Others migrated to the cities in search of employment and education. Many of these individuals and their families never returned to their reservations. Whatever the reason, many AI/AN people are firmly rooted in the cities.

The allocation of IHS funds to the urban Indian program has been a source of controversy between urban Indian and tribal leaders. Concerned that scarce resources would be redirected from the reservations to the cities, some tribal leaders have opposed the expansion of urban programs. Our data do not support the redirection of funds previously designated for rural AI/ANs living on native lands, since it appears that both populations are vulnerable and in similar great need of health services, epidemiologic surveillance, and prevention activities. The recent drive for health system reform may benefit the health concerns of the urban AI/AN population. Under President Clinton's proposed Health Security Act of 1993 (section 8302), urban AI/ANs will be eligible for the same full health care benefits extended to rural AI/AN residents. Under this plan, all AI/AN enrollees could receive their care in an IHS, a tribal, or an urban Indian facility. Until a solution is reached in the context of health system reform, the responsibility for the health needs of urban AI/ANs must continue to be addressed at local, state, and federal levels in consultation with existing urban Indian programs.

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We thank John Kobayashi, MD, MPH, and Ernest Kimball, MPH, for their assistance with the project. We are very grateful to Abraham Bergman, MD, Lawrence Berger, MD, MPH, Thomas Koepsell, MD, MPH, and Steven Helgerson, MD, MPH, for reviewing earlier drafts of the manuscript. We are also deeply indebted to Jim Allen, Cindy Crosap, and Bi-Lan Chiong for their expert technical assistance.

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Exhibit E.

URBAN INDIAN HEALTH FACTS

Urban Indians make up over 60% of the total Indian population.

Urban Indian population has grown over 30% in the last 3 decades.

Urban Indians are undercounted by the U.S. Census and not included in statistical data gathered for urban areas.

Urban Indians are dispersed throughout all census tracts in urban areas; no ghettos. As invisible minorities they are excluded from public block grants; minority assistance programs; start-up capital for businesses; and mainstream markets.

Urban Indian unemployment is double that of all other races [in some cities, like Boston, there is evidence that the Indian unemployment rate is quadruple the rate for all other races].

Urban Indian poverty levels are three times that of any other race.

Urban Indian high school drop out rate is over 75%.

Urban Indian business development rate is the lowest of any race.

Urban Indians have higher mortality rate from alcoholism and related causes than other races.

Urban Indian suicide rate is four times that of all other races.

Urban Indians have three times the national rate for diabetes and heart disease. Health care is unavailable to 50%-75% of Urban Indians.

Urban Indian mental health patients increased 200% from 1988 to 1990.

Urban Indians are citizens of both the United States and their sovereign Tribal Nation.

This fact sheet is derived from one developed by The National Urban Indian Policy Coalition.

Southern California
TRIBAL CHAIRMEN'S
Assoc., Inc.

July 23, 2000

Honorable Ben Nighthorse Campbell
United States Senate
Hart Building Room
Washington, DC 20518

Re: Written Testimony Indian Health Care Improvement Act S2526
Ben Senate Campbell

We support the hearing on S. 2526, to reauthorize Indian Health Care Improvement Act.

Problem: One of the major barriers of providing any services to Indian County is the start-up and stop of individual families services, which many services require many applications, forms, requests, and statements, for a variety of health services. Our example: one complete application for TANF Cash Assistance, one complete application for Food Stamps, one complete application for Medi-Cal, one complete application for Child Support Enforcement, and to basically six other agencies that deal with economically disadvantage, high risk families.

We need to solve the application barriers by having a cognizant agency for recipients that issue a "one stop card", as the one stop application, which basically certifies the eligibility of the individual to receive Medi-Cal, TANF (cash assistance), Food Stamps, and other Services.

We have attached a chart that better conceptualizes our One Stop Application network, for the economically disadvantage, and high risk family. We hope Senate will consider S2526, becoming a partnership into a One Stop Application process for economic disadvantage, high risk family.

Respectfully,

Ralph Goff
Tribal Chairman

Respectfully,

Denis Turner
Executive Director

See attached Proposed Amendments.

P.O. 1478 • Valley Center, CA 92082
Ph. (760) 749-0918 • FAX (760) 749-5615

INDIAN HEALTH CARE IMPROVEMENT ACT

PROPOSED AMENDMENT

A Tribal provision in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, provided language that would allow Indian Tribes to administer a TANF (cash assistance) program.

One of the major barriers of providing any service to Indian Country is the lack of transportation. Rural public transportation systems are sporadic and in many areas non-existence. Tribal members of Tribal TANF programs must complete one application for cash assistance, travel to the local county welfare office to complete a similar application for the Federal Medicaid program.

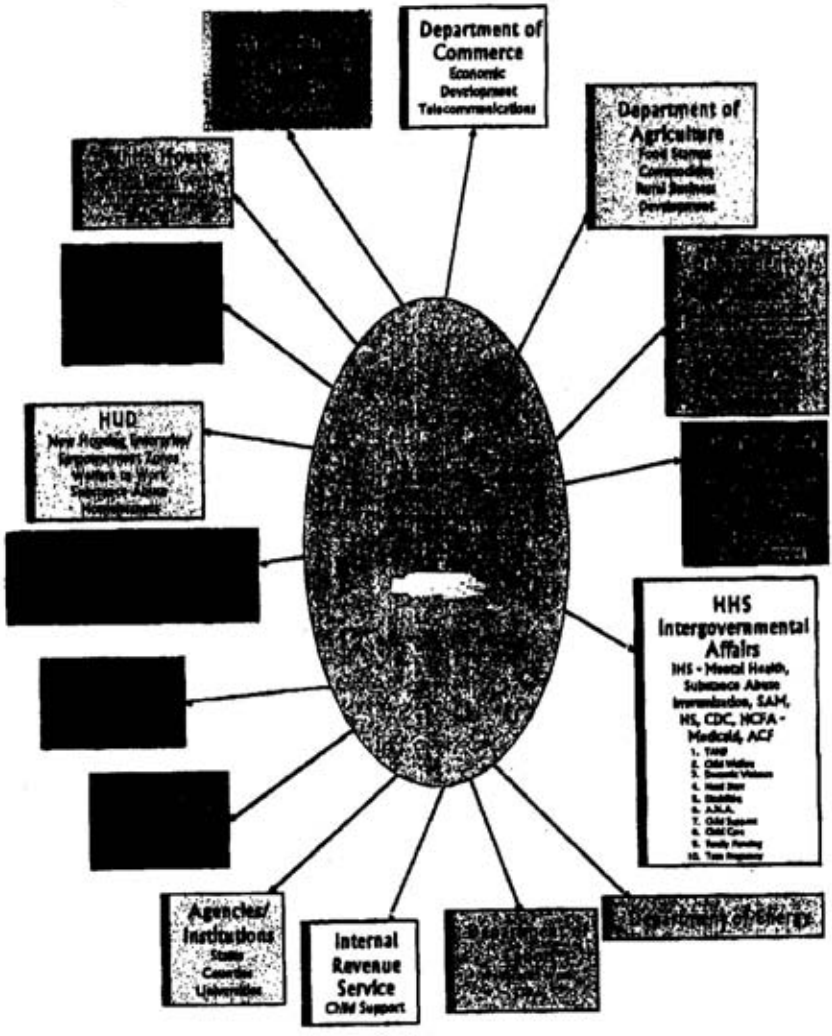
The State agency is responsible for conducting the Medicaid Program eligibility determination on Indian reservations, which historically has resulted in under representation of Indian people. .

Therefore, an amendment to the Indian Health Care Improvement Act that will allow Tribal TANF programs to determine eligibility for Medicaid program will increase Indian participation and provide a one-stop application for services.

AMENDMENT

Indian Tribes that administer a Tribal TANF program are authorized to determine eligibility for the Federal Medicaid program.

Visualizing Our Network



Health and Human Services

TANF Block Grant/New

Medicaid

Child Support Enforcement

Child Care/Head Start

Social Services Block Grant

Teen Pregnancy Prevention/Family Planning

Substance Abuse Treatment & Prevention

Mental Health Treatment & Prevention

Family Violence Programs/Violence Against Women

Children's Mental Health Services

Community Services Block Grant

Individual Development Accounts

Assets for Independence Demonstrations (to establish Individual Development accounts for low income individuals/families)

Job Opportunities for Low Income

Community Economic Development/Rural Community Facilities

Fatherhood Programs

Department of Agriculture

Distance Learning (Funding to encourage/improve telecommunications/computer networks to provide education for rural areas)

Rural Development (Pursuing ways to stimulate improvements in the economic, social or environmental well-being of rural residents through technical and financial assistance)

Wood in Transportation (Offers technology transfer and value added business development assistance for improved transportation and infrastructure and markets for wood)

Rural Business Enterprise Grants (Help finance and facilitate development of small and emerging private business enterprises located in rural areas)

Rural Business Opportunity Grants (Provides funds for technical assistance, training/planning activities that improve economic conditions in rural areas. To promote sustainable economic development in rural communities with exceptional needs)

Food Distribution Program on Indian Reservations (Commodities)

Food Stamps (Helps low-income households but food for a more nutritious diet)

Community Facility Program (A community facility is a service center that provides essential public services such as a welfare services building)

Emergency Food Assistance Program

Child Adult Care Food Program

Community Food Projects (to meet the food needs of Low-income people)

WIC

Department of Justice

Tribal Courts

Felony/ fleeing felons criminal information

Domestic Violence (STOP Violence Against Women)

Drug Abuse Programs

Department of Treasury

Internal Revenue (Tax returns & Child Support)

Department of Education

Adult Education

Education Block Grant

Education for Disadvantaged

Special Education

Vocational Education

Child Care Access

Rehabilitation Education

Life Skills

Learning Disabilities

Even Start

Literacy Grants

Department of Labor

WIA

Adult Job Training

Welfare to Work

School to Work

Youth Opportunity Program

CHEROKEE NATION
P.O. Box 948
Tahlequah, OK 74465-0948
918-456-0671

Chad "Corntassel" Smith
Principal Chief

Hastings Shade
Deputy Principal Chief

April 7, 2000

Paul Moorehead
Majority Staff Director
Committee on Indian Affairs
838 Hart Senate Office
Washington, DC 20510

Dear Mr. Moorehead:

The Committee on Indian Affairs has scheduled a field hearing in Denver, Colorado on draft legislative *"to reauthorize the Indian Health Care Improvement Act of 1976, as amended"* for Monday December 6, 1999. We offer this letter as support for a proposed amendment to the IHCIA.

It has been brought to our attention that the language, *TANF Tribes are authorized to determine eligibility for Federal Medicaid,* was deleted from the proposed bill for the reauthorization of the Indian Health Care Improvement Act (IHCIA) of 1976. By deleting the proposed amendment language from the reauthorization bill, TANF Tribes would be unable to evolve, as the States have evolved, and provide one stop programs that will ease the stress for Native American clients. The State of Oklahoma's assistance programs has been evolving for decades and have Federal statutory and regulatory relief for program developments.

Tribal one-stop services will ease the stress on clients regarding transportation (a major barrier to delivery of services) and redundant and laborious program applications that need to be completed for eligibility determination.

We strongly recommend that this language be reinstated to allow tribes the flexibility to develop their own program according to their individual needs.

Sincerely,

Jerry D. Smith
Director
Family Assistance Department
Cherokee Nation

OSAGE TRIBE OF INDIANS
OSAGE TANF PROGRAM
1333 Grandview
Pawhuska, Oklahoma 74056
1-888-822-1248
918-287-1248

Paul Moorehead
Majority Staff Director
Committee on Indian Affairs
838 Hart Senate Office
Washington D.C. 20510

Dear Mr. Moorehead:

The Committee on Indian Affairs has scheduled a field hearing in Denver, CO on draft legislation *"to reauthorize the Indian Health Care Improvement Act of 1976, as amended"* for Monday Dec. 6, 1999. An Osage Tribal representative will not be able to attend the hearing. However, we offer this letter as support for a proposed amendment to the IHCIA.

The Osage Tribe is administering a Tribal TANF Program under terms in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. We have discussed the possibility of the Tribe administering a Food Stamp Program and determining Medicaid eligibility.

Tribal one-stop services will ease the stress on clients regarding transportation (a major barrier to delivery of services) and redundant and laborious program applications that need to be completed for eligibility determination.

The Osage Tribal TANF Program supports the National Congress of American Indians, Resolution # GRB-98-046, *"Develop HHS and DOA, regulatory language to allow Tribal TANF Tribes to provide one stop shop for cash assistance, Food Stamps and Medicaid eligibility determination."*

It has been brought to our attention that the language, *TANF Tribes are authorized to determine eligibility for Federal Medicaid*, was deleted from the proposed bill for the reauthorization of the Indian Health Care Improvement Act (IHCIA) of 1976. By deleting the proposed amendment language from the reauthorization bill, TANF Tribes would be unable to evolve, as the States have evolved, and provide one stop programs that will ease the stress for Native American clients. The State of Oklahoma's assistance programs has been evolving for decades and have Federal statutory and regulatory relief for program development.

Therefore, we support the proposed amendment to the Indian Health Care Improvement Act that will authorize Tribal TANF Programs to determine eligibility for the Federal Medicaid Program.

Sincerely,

Raymond Lasley, Director
Osage Tribal TANF Program

cc: Virginia Hill, Director Social Services, Southern Indian Health Council
Sarah Hicks, Welfare Reform Program Manager, NCAI

TESTIMONY OF JACOB ADAMS
PRESIDENT, ARCTIC SLOPE REGIONAL CORPORATION

REGARDING
S. 2526, A BILL TO AMEND THE INDIAN HEALTH CARE IMPROVEMENT ACT TO REVISE AND EXTEND SUCH ACT

BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS

HEARING HELD JULY 26, 2000

Mr. Chairman and Members of the Senate Committee on Indian Affairs, my name is Jacob Adams and I am the President of Arctic Slope Regional Corporation (ASRC), an Alaska Native Corporation created under the Alaska Native Claims Settlement Act (ANCSA) and headquartered in Barrow, Alaska. ASRC has over 7,500 Alaska Native Shareholders and represents the interests of all of the North Slope Inupiat Eskimo people in the northern most region of Alaska. I appreciate this opportunity to provide testimony to you on behalf of ASRC regarding Title IV of S. 2526.

I am submitting written testimony to demonstrate ASRC's support for Title IV, Section 406(g), of S. 2526. This important Section of S. 2526 amends Section 1621e(f) of the Indian Health Care Improvement Act (IHCIA) (25 U.S.C. § 1621e(f) (2000)). This amendment clarifies that neither the United States, acting through the Indian Health Service (IHS), nor an Indian tribe or tribal organization under a funding agreement pursuant to the Indian Self-Determination and Education Assistance Act, shall have a right of recovery for reasonable charges billed or expenses incurred in providing health services if the injury, illness, or disability for which health services were provided is

covered under a self-insurance plan funded by an Indian tribe or tribal organization, or urban Indian organization. Section 406(g), however, does allow such recovery where there is specific written authorization by the governing body of an Indian tribe.

The Current Provisions of the IHCIA

The IHCIA, as currently written in the United States Code, has been interpreted to negatively impact those Indian tribes or tribal organizations that provide health care coverage to employees through a self-insurance plan. The IHCIA defines the term "Indian tribe" to include Alaska Native Corporations, such as ASRC, created pursuant to ANCSA. See 25 U.S.C. § 1603(d) (2000). ASRC currently has a self-insurance plan, which fits within the IHCIA's definition of a "self-insurance plan funded by an Indian tribe or tribal organization."

The IHCIA was enacted in 1976. See Pub. L. No. 94-437, 90 Stat. 1400 (1976). In 1988, Congress added a provision to the IHCIA, allowing the Federal government to recover from third-party payors reasonable expenses incurred by the IHS in providing health care services. See 25 U.S.C. § 1621e(a) (2000). In 1992, Congress broadened that recovery provision to allow the same type of recovery by tribes and tribal organizations contracting with IHS to provide health care services. Also in 1992, Congress added an exception to this right of recovery whereby, "[t]he *United States* shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization." 25 U.S.C. § 1621e(f) (emphasis added).

There is a lack of parity between the right of recovery provision under 25 U.S.C. section 1621e(a), which is available to the "United States, an Indian tribe, or a tribal organization", and the exemption on recovery under 25 U.S.C. section 1621e(f), which is available only in cases where the "United States" is seeking recovery. Thus, as currently written, the IHCIA has been interpreted to provide that a self-insurance plan funded by an Indian tribe can only avoid being recovered against when the health care provider is the United States, acting through IHS, and not when the provider is a tribe or tribal organization contracting with IHS. The result is that Indian tribes are essentially being billed for health care provided to tribal members who are entitled to free health care services from the IHS and from tribes and tribal organizations contracting with IHS. This was not Congress' intent when enacting the IHCIA.

The foregoing result is the unfortunate situation that ASRC has been faced with. ASRC's self-funded insurance plan is being billed by a tribal health organization that has a contract to provide IHS services to American Indians and Alaska Natives. Whereas, if the IHS were providing the health services directly, ASRC's self-funded insurance plan would be exempted from such recovery. This result is not compatible with Congress' intent to provide health care services to American Indians and Alaska Natives, at the Federal government's expense.

In a House Report accompanying the 1621e(f) exception, the Committee stated that it "does not intend 25 U.S.C. Section 1621e to be interpreted to authorize the [IHS] to seek reimbursement from tribally operated self-insurance plans." H. Rep. No. 102-643(I), 102d Cong., 2d Sess., *reprinted in* 1992 WL 163494, *192-93. The Committee

went on to state that "[t]his would result in shifting the legal obligation to pay for Indian Health Services for tribal members to the tribes themselves." This rationale for exempting tribally funded self-insurance plans from the collection efforts of the IHS should equally apply to the collection efforts of Indian tribes and tribal organizations contracting to provide IHS services.

The Recovery Provisions as Clarified by S. 2526

As stated above, the IHCIA defines the term "Indian tribe" to include Alaska Native Corporations created pursuant to ANCSA. Section 406(g) of S. 2526 would limit the ability of the IHS, or a tribe or tribal organization, to recover from a self-insurance plan funded by an Indian tribe, including an ANCSA Corporation. As a result, under Section 406(g) of S. 2526, neither the IHS, nor a tribe or tribal organization contracting to provide health care to American Indians and Alaska Natives, shall have a right of recovery under the self-insurance plan funded by ASRC, without specific written authorization of the governing body of ASRC.

This clarifying provision in S. 2526 would further the Federal policy of providing health care to American Indians and Alaska Natives at the expense of the Federal government, but not at the expense of tribal members or Indian tribes. This provision would clarify that such Federal responsibility for health care was not intended to be borne by an Indian tribe, including an ANCSA Native Corporation such as ASRC.

On behalf of the 7,500 Inupiat Eskimos represented by ASRC, I would like to thank the Committee for allowing me to submit my testimony, for the record, in support of Section 406(g) of S. 2526.

NATIONAL
INDIAN
CHILD
WELFARE
ASSOCIATION

STATEMENT OF THE

NATIONAL INDIAN CHILD WELFARE ASSOCIATION

SUBMITTED TO THE SENATE COMMITTEE ON INDIAN AFFAIRS

REGARDING S. 2526

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

JULY 26, 2000

Terry L. Cross
Executive Director

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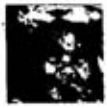

The National Indian Child Welfare Association appreciates the opportunity to submit this testimony on. S. 2526, a bill to amend the Indian Health Care Improvement Act (herein referred to as "The Act"). Our organization is based in Portland, Oregon. Our comments will focus on the following themes as they pertain to S.2526:

1. *Systems of Care and its relationship to behavioral health services and our recommendation that S. 2526 include this concept;*

2. *The serious need for increased funding to expand services and provide better access to mental health care for American Indian/Alaska Native children;*

3. *The need for Indian Health Service (IHS) to acquire and provide specific data related to Indian children's mental health.*

Our recommended changes to S.2526 begin on page 9 of our testimony.

The National Indian Child Welfare Association (NICWA): NICWA provides a broad range of services to tribes, Indian organizations, state and federal agencies and private human service agencies throughout the United States. These services are not direct client services such as counseling or case management. They are services that strengthen the programs that directly serve Indian children and families. NICWA services include: (1) professional training for tribal and urban Indian human services and mental health professionals; (2) consultation on human services and mental health program development; (3) facilitating child abuse prevention efforts in tribal communities; (4) analysis and dissemination of public policy information that impacts Indian children and families; (5) training institutes on Indian children's mental health topics; and (6) helping state, federal and private agencies improve the effectiveness of their services to Indian people. In addition to maintaining a strong network in Indian country by working closely with the National Congress of American Indians and tribal governments across the United States, we have established mutually beneficial partnerships with child and family welfare organizations such as the Federation of Families for Children's Mental Health, the Child Welfare League of America, and Casey Family Programs.

SYSTEMS OF CARE AS THE CORNERSTONE OF BEHAVIORAL HEALTH
What is a system of care? Within the field of children's mental health, a system of care is a formal collaboration of the family and community members, professional and other organizations committed to enhancing the lives of emotionally disturbed children and their families. The purpose is to bring cohesion to the strategies and services aimed to rehabilitate these children. Specific values set the principles that drive a system of care. These principles evolve into specific practices that create change.

Systems of care has evolved over the past several years from the growing awareness of the absolute need for all stakeholders in children's well-being to work together. Service providers now recognize that simply dispensing medication and providing adjunctive

psychotherapy services fall short of what children and their families need to recover from or cope with mental illness. They recognize that the causes of mental health disorders are complex and that the impact of mental illness requires collaboration and partnerships among many parties.

Wraparound services comprise a full array of human services. *Case management, or care coordination*, connects all parties providing this full array of services into a collaborative web. Systems of care include formal partnerships between tribal, state or county agencies (*partnerships)*, multi-disciplinary teams (*collaboration)*, deep *family involvement* and the accessibility to service providers far beyond the typical 8 a.m. to 5 p.m. workday. Wraparound services include children and families in the planning of the treatment for the children. In addition to professionals, effective systems of care bring into this planning the significant persons involved in the child and his/her family's life, such as spiritual healers, extended family and community elders. Professionals may include educators, child protection services, the juvenile justice system and mental health professionals (Cross, Earle, Echo-Hawk Solie and Manness, 2000).

S.2526 combines the fields of substance abuse and mental health into a behavioral health department and emphasizes traditional healing as an important part of wellness. We agree with this approach, but the bill does not, unfortunately, encourage systems of care. This omission is inconsistent with other HHS agency policy and today's most promising practices.

Throughout the past decade, the Center for Mental Health Services (CMHS), a division of the Substance Abuse and Mental Health Services Administration, has emphasized the importance of systems of care in meeting the complex needs of children suffering from mental illness and their families. Within Indian country, during the past seven years, CMHS has funded a total of 8 tribal mental health programs that provide services to Indian children with severe mental health challenges. These programs are excellent examples of tribes and tribal organizations developing creative, effective mental health systems of care. We are attaching to this testimony a copy of the *Promising Practices: Cultural Strengths and Challenges in Implementing A System of Care Model in American Indian Communities* (Cross et al., 2000). This monograph describes 5 of the 8 programs. Following are excerpts from this monograph that describe the extent of collaboration inherent in systems of care. In this case the description is of the Sacred Child Project, which is coordinated by United Tribes Technical College and serves 5 sites in North Dakota, South Dakota and Montana.

> "*Sacred Child* staff and spiritual consultants have an unconditional love for the children and their families who participate in the project."
>
> "Participants are visited by a care coordinator and, if available, a parent coordinator..., they understand the community dynamics and culture and they are aware of the services and programs in the community .... [they must] be willing to train to become certified in care coordination."

"Their [the child and his/her family] application is then forwarded to the local Wraparound Review Intake Team (WRIT), a multidiscipline team composed of parents, care coordinators and representatives from cultural, spiritual, child welfare, mental health, law enforcement, juvenile justice, education, alcohol and substance abuse prevention and domestic violence areas."

"The next step in the wraparound process is to set up a meeting of the child and family support team. At this meeting, the parents or primary caregivers and the child, if age appropriate, meet other members of the child and family support team (CFST). This team is comprised of people the family has identified as being part of their natural support system and the service providers from the systems with which the child is involved."

"The purpose of the support team meeting is to develop a plan of care appropriate for the family's strengths and culture."

From the above example, one can see the high degree of involvement of Sacred Child Project staff with families and community members, and how a system of intervention extends beyond providers to community members that are known to the family. When a family and community are brought into a system that works together to promote healing, the motivation to succeed exceeds discrete efforts by one individual or one agency acting independently. With the work spread throughout formal and informal entities, a system can be available 24 hours/day to stabilize families. Different players are called into action based upon the need at any given time. For example, a mental health specialist, traditional or mainstream, may be called to respond to a suicidal teen; or a protective services worker may put a remedial care plan into immediate action to prevent child abuse and the removal of a child into foster care.

According to parents and staff interviewed for this monograph, this level of involvement has resulted in saving lives of suicidal adolescents, reducing school absenteeism and expulsion, improving school grades, decreasing the rate of recidivism into the juvenile criminal justice system, increasing self esteem, preventing child abuse, and keeping children within their homes as opposed to placing them into foster care or residential treatment. These changes transform the lives of children and families. One can speculate that the cost savings would be enormous by providing extensive services at the front end versus the exorbitant costs of "back end" services such as incarceration, protective placement and in-patient psychiatric hospitalization, as well as general assistance. Providing effective services to children will likely also save costs from social security disability benefits, since chronic, severe mental illness often renders people unemployable.

CMHS recognizes that many Indian communities have gone too long without mental health services and that these communities lack the infrastructure to support an effective mental health system. In its commitment to bridging the gap in services to Indian children, CMHS funded nine tribal and urban Indian programs whose mission is to design systems of care. These projects, called Circles of Care, are in addition to the 8 sites

mentioned above providing services. They have been given three years to establish partnerships and to involve the community in designing a system of mental health services for their children. IHS is aware of this emphasis in mental health policy and is, in fact, one of the partners in these CMHS funded grants.

INDICATORS OF NEED FOR IMPROVED MENTAL HEALTH SERVICES TO CHILDREN IN INDIAN COUNTRY

In general, mental health services are scarce for all children. But for Indian children, access is more problematic. The disparity in available resources parallels the scarcity of data relevant to Indian children and mental health.

Available Statistics: Severe life stresses place Indian children at high risk for mental health problems. On a national level Indian communities are affected by very high levels of poverty, unemployment, accidental death, domestic violence, substance abuse, child neglect and abuse, and suicide. These at-risk factors lead most authorities to agree that there is an inordinate, unmet need for mental health services in tribal communities (Swinomish Tribal Mental Health Project, 1991).

There is very little data on the mental health needs of Indian children and adolescents (Deserly and Cross, 1996; U.S. Congress, Office of Technology Assessment, 1990). We can make some extrapolations about the level of need for Indian children and the importance of addressing those needs from statistics pertinent to the general population, particularly since we know that minorities with mental health disorders are less likely to receive treatment and more likely to be placed in correctional facilities (Knitzer, 1982). We know the following to be true:

1. Mental disorders account for 4 of the 10 leading disabilities in established market economies worldwide (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999);

2. The cost of mental illness in the United States was $148 million in 1990 (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999);

3. Worldwide, depression is the leading cause of disabilities among persons *age five* and older (The National Institute of Mental Health: *Science on our Minds: The Numbers Count,* 1999);

4. The estimated national incidence of emotional disturbance is 11.8 percent of the population under the age of 18 (Gould, Wunsch-Hitzig and Dohrenwend, 1980).

We can see that the cost of mental illness is extraordinary. In Indian country where mental health services are extremely scarce and the need is disparately great, we can assume that both the life-long personal and financial costs of not providing adequate mental health services to our children will be enormous.

The 1990 Census reports that almost two million American Indian people are living in the United States. Of this number, 39 percent are under the age of twenty. Research estimates that there are approximately 93,000 emotionally handicapped Indian children in the United States (Deserly and Cross, 1996).

Although epidemiological research is scarce, we know that Indian children suffer from catastrophic rates of posttraumatic stress, which, if untreated, creates a generation of adults who suffer from severe, chronic mental illness. Boarding school surveys have identified Indian youth as being at high risk for mental health disorders. According to an unpublished paper by the Bureau of Indian Affairs (1995), *Therapeutic Residential Schools – Promise of the Future*, off-reservation, residential school students are either "at risk" or are "very high risk" students. Most of these students have suffered sexual, physical and emotional abuse, abandonment and/or rejection and have been involved in self-destructive behaviors. Supporting documentation shows that many students with mental health problems are on probation from the juvenile court system. In addition, the scope of alcohol and drug abuse among entering students is overwhelming: 80 percent to 100 percent! Over 80 percent are from home environments where one or both parents have been identified as having a substance abuse problem. The paper further reports increasing dysfunction in all areas investigated in mental health screenings. The majority of students screened (approximately 95 percent) reported critical medical, social, mental and educational needs that are not being met.

Historical Factors. The effects of past forced removal of Indian children from their native societies and placement into boarding schools, adoptive and foster homes are only now being fully recognized. Children changed in ways that their parents and grandparents could not understand. Many returned home for vacations expressing serious identity confusion. They grew ashamed of being Indian and bitterly disowned the values and lifestyle of their families. After years in boarding schools, they grew up unable to fit comfortably into either Indian or non-Indian societies (Swinomish Tribal Mental Health Project, 1991). Many times, these children never returned to their homes. For those who did, communication was damaged because children had been forbidden to speak their native languages. Many children were unable to converse with their own parents. Having been denied normal Indian childhood experiences and role models, they were delayed in their social and emotional development (Attneave, 1977).

As these children became parents, they met unprecedented challenges. They lacked family experience from which to learn parenting skills. They struggled with major depression and attachment disorders resulting from their trauma of forced separation. Generations of Indian parents resorted to substance abuse, neglected their children and found themselves overwhelmed by the challenges of parenting (Hollow, 1982). This yielded an upsurge in child neglect and abuse resulting in the removal of successive generations of Indian children from their parents. Thus the history of removal of Indian children from their families created a cycle of multi-generational trauma that continues to cause emotional illness in today's generation of Indian children.

Without a commitment on the part of IHS to mental health systems of care, the outlook for Indian children is dismal. Given the knowledge we now have about the positive outcomes of systems of care established within Indian communities, it makes good sense for IHS to make such a commitment. Should IHS do so, the outlook is optimistic. There are three reasons for the optimism. One is that IHS is beginning to develop some expertise in systems of care via their collaboration with the CMHS grants. The second is that today's research is clarifying the neurobiological processes involved in trauma, and this research points to promising remedies. The third reason is that Indian communities have demonstrated their competence in and desire to develop systems of care.

Lack of Access and Specific Services Needed: Today's research reports that there is a narrow window of opportunity (six months) for treating victims of trauma before they suffer from neurological damage (Perry, in press; Perry and Marcellus, 1977). Untreated, repetitive trauma can result in learning deficits, posttraumatic stress disorder and a myriad of mental health symptoms that seriously interfere with a person's ability to cope with life. These symptoms generally continue throughout adulthood (Perry, in press; Perry and Marcellus, 1977). The repercussions of persistent trauma contribute to the high rate of Indian youth dropping out of school, entering the juvenile justice system and abusing alcohol and drugs. They also contribute to the high teenage pregnancy rates and high rates of babies affected by fetal alcohol and drug abuse.

Today's research documents the results of separation of children from their parents. Attachment disorders reflect the neurobiological impact of this trauma. Research also shows the correlation between mental health disorders and high rates of diabetes, cardiac and other diseases (Koren, DeChillo and Friesen, 1992; National Institute of Mental Health, *Science on our Minds: The Numbers Count*, 1999; National Institute of Mental Health, *Science on our Minds: Depression Can Break Your Heart,* 1999). Given that American Indians have the highest rate of diabetes, obesity and heart illnesses, there is a great need for mental health services as prophylactic, medical health measures. Additionaly, one can extrapolate, from the research on the neurological impact of trauma, that mentally ill children, left untreated, are at high risk for serious health problems as adults.

There are several reasons for disparity of mental health services to Indian children.

Low IHS Funding. Historically, mental health, particularly mental health services for children, has been low on the IHS list of funding priorities. In 1988, only 1.3 percent of the total budget was allocated for mental health and social services for all age groups (U.S. Congress, Office of Technology Assessment, 1990). Today, IHS allocates approximately 3 percent of its budget for mental health and social services combined with no set policy for allocation to children's services. These funding decisions have resulted in severe shortages in mental health, which is exacerbated by the fact that 90 percent to 95 percent of psychiatrists and psychologists work in metropolitan areas. (Wagenfeld, Murray, Mohatt and DeBruyn, 1994). There is a critical need for pediatric neuropsychiatrists who specialize in fetal drug and alcohol disorders. Shortages of this

nature result in poor assessment of need, inadequate crisis intervention and misdiagnosis. These are potentially life threatening.

Jurisdictional Confusion. Confusion between agencies regarding who has the responsibility of serving Indian children often leads to no services. Federal, tribal, state and local governments all bear some degree of responsibility for the mental health of all children. Their perception that 'the other agency is responsible' has resulted in virtually no coordination of services, let alone the development of a formalized system" (Cross et al., 2000).

Geography. Another reason for disparate mental health services is geography. Great distances, sometimes hundreds of miles, prevent access. In Alaska, many villages can be reached only by air in winter and in the summer months some villages are also accessible by boat. Many tribal programs have very large service areas. Clients may have to travel hundreds of miles for an appointment; children may placed in homes or treatment centers far from heir home communities, thus making it very difficult for family visits. If services are home-based, only a few clients a day can be seen because of the enormous distances a worker has to travel.

Cultural Obstacles. Although state and county mental health programs which are federally funded are theoretically available to all residents, mental health agencies generally have been unsuccessful in serving Indian people. For the most part, services offered by state and county agencies are culturally inappropriate for Indian clients, many of whom feel uncomfortable dealing with non-tribal agencies. When mental health providers are unfamiliar with tribal lifestyles, family values or communication style, there is a high probability of misunderstanding. Many non-Indian providers are not even aware that important value differences exist. This lack of awareness increases the danger of Indian clients being misunderstood, labeled or rejected (Swinomish Tribal Mental Health Project, 1991). Misdiagnosis of Indian clients can result in serious medical and emotional damage. Cultural norms, such as spiritual visions, are sometimes misinterpreted as psychoses, for example, and treated with medication when no medication is necessary.

Inadequate Diagnostic Services. Because of the lack of resources, Indian communities have dangerously poor access to psychiatric services and the latest neuropsychiatric information and technology that is prerequisite to accurate diagnosis. Inaccurate diagnosis can result in inappropriate prescribing of medication and ineffective treatment plans, as well as impacting school decisions for special education assessment and placement, accepting children into regional centers that guarantee life-long care, denial of social security disability benefits, etc.

There is great complexity in diagnosis. This complexity is further compounded by an increase in children struggling with multiple mental health disabilities, including those related to fetal drug and alcohol abuse. The field of pediatric neuropsychiatry is important in accurate diagnosis. Accurate diagnosis is prerequisite to developing appropriate treatment plans and for prescribing medication. Assessment is an evaluation

of the various symptoms; diagnosis is the determination of the illness. Although assessment leads to a diagnosis, without an accurate diagnosis, service providers cannot develop an effective treatment plan.

Hazards of Misdiagnosis: The following example illustrates the life threatening consequences of inadequate diagnosis.

One psychiatric social worker reports spending over 200 man hours identifying a psychiatrist with sufficient expertise to diagnose and prescribe treatment to a 9-year-old Indian youth who had been grossly effected by fetal alcohol and drug abuse, including methamphetamine, cocaine, LSD, marijuana and hashish. A pediatrician treated this child for attention deficit disorder; however, he failed to diagnosis the other psychiatric disorders of the child. The treatment prescribed, therefore, was inappropriate. Additionally, the county mental health system said the child did not have a mental health disorder and denied the child access to the day treatment program and services. The school special education program was ineffective in dealing with the severe behavioral problems resulting from the mental illness. After months of exploration, the Indian behavioral health program located a psychiatrist who recognized that the child was schizophrenic in addition to suffering from attention deficit disorder, pervasive developmental disorder and fetal drug and alcohol effects. For the first time, the child's psychotic symptoms were identified and then addressed. Because of long-term, high dosages of Ritalin, the child developed an irreversible cardiac problem. Had this child had access to a neuropsychiatrist trained to work with children, successful diagnosis and resulting treatment would have been implemented several years prior, and the cardiac problems would likely have been avoided. More alarming is that many tribal programs have no mental health professionals who would recognize the need for specialized assessment and diagnosis. Children receiving services in these programs are at high risk for misdiagnosis and ineffective treatment.

Benefits of Accurate Diagnosis: Within a year after the above-discussed child entered into treatment with an appropriately trained psychiatrist, he entered the County mental health's day treatment program. He was accepted into the state's regional center. His psychotic symptoms abated. His family received home-based behavioral management services as well. This child will never function "normally," but there is a life-long care plan set up for him which will be revisited on a regular basis and modified according to need.

IMPORTANCE OF DATA.

There are no hard figures on how many dollars IHS allocates to children's mental health. There is a lack of IHS data documenting the extent and the severity of these children's mental illnesses. State and county agencies often lump American Indian/Alaska Native into the "all other" category, so their statistics omit data on American Indian children. To make matters worse, state and county workers frequently identify Indians as Hispanic because of Spanish surnames. The undercount of Indian children struggling with mental illnesses undermines efforts to address these problems.

While IHS has a mental health/social services data collection system, there are many problems inherent in the system. Not all behavioral health programs use the system. It competes for statistics with a chemical dependency data collection system, and workers do not want to input data for two separate systems. The forced choices of the program create confusion on how to respond to the specific data fields and important information is only intermittently reported. Finally, what data is collected is not disseminated.

The data collected by IHS is so problematic that it makes it difficult for us to present a recommendation that pertains to dollar allocations. The lack of reliable data allows state and county agencies to avoid developing culturally specific programs for Indian children, as well as impeding Indian tribes and urban organizations from successfully competing for grants.

RECOMMENDATIONS
(changes in language are printed in **bold**)

Issue Number One: The Act fails to address today's most promising mental health practice – systems of care for children's mental health.

Recommendation: Make the following changes in language:

- Sec. 701(a)(1) – add the following language at the end of the paragraph: **and which promotes the development of systems of care;**
- Sec. 701(a)(2) – insert the following language after the phrases: develop tribal plans **promoting systems of care** ...organizations to develop **local systems of care** plans...
- Sec. 701(b)(1) – add paragraph **"(D) a design for a system of care rooted in wraparound service.**
- Sec. 701(d)(1) – add at the end of the paragraph **within a coordinated system of care.**
- Sec. 703(a)(1) –insert the following language after the phrase: ... program of comprehensive behavioral health **systems of care addressing**
- Sec. 707(c)(2) – add paragraph **"(F) to develop collaborative systems of care.**
- Sec. 910(b)(6) – insert the following language after the phrase: ... avoids duplication of existing services, **and facilitates the** development **of a system of care.** "

Justification: Systems of care is consistent with federal policy for mental health services to children and families. It involves the family and natural, indigenous systems of care that facilitate the empowerment of children and families, as well as expanding resources. It helps avoid duplication of services and contributes toward sustainability of behavioral

health services within an economy of dwindling resources. Systems of Care reduce costs by lowering the numbers of children placed out of the home (juvenile detention, foster care, residential treatment). They promote great success in prevention and treatment of mental health disorders by engaging the community in developing prevention and treatment strategies. The community becomes part of the treatment plan, thereby increasing the number of people supporting the child and the family in need.

Issue Number Two: The technical assistance language in S. 2526 is general and does not specifically address systems of care as a promising practice.

Recommendation: (insert the following changes in language.)

- Sec. 709(a)(2) – insert the following language after the phrase: concerning behavioral health **systems of care** ...
- Sec. 709(b) – insert the following language after the words: behavioral health issues, including **systems of care** ...

Justification: Indian communities need the benefits of state of the art information regarding current mental health services. Behavioral health program personnel should have access to the technical assistance that would assist them in developing mental health systems of care within their communities. In order to garner support for systems of care, tribal council members, other leaders and community members need training and education in this area. IHS staff could benefit from this such training for the same reasons. An additional benefit would be that an increased awareness would encourage collaboration between behavioral health services delivered directly by IHS to tribal communities and tribally run services.

Issue Number Three: There is a severe lack of mental health personnel trained to work with children.

Recommendation: Amend Sec. 127(1) as follows: change the number 500 to **1,000.**

Justification: S.2526 moves toward addressing the mental health needs of Indian children by acknowledging the critical lack of mental health practitioners working in American Indian/Alaska Native programs, particularly those specializing in working with children and families. The Act calls for the recruitment of 500 mental health providers with a minimum of 200 qualified to work with children. Given the extraordinary unmet need for mental health services for Indian children, 500 new practitioners is grossly inadequate. This is particularly true when we are recruiting practitioners whose expertise ranges from professional to paraprofessional and when you consider that rural case loads are smaller than urban case loads due to time spent on travel. Furthermore, the figure of 93,000 Indian children needing mental health services is a conservative estimate. There is no indication of a decrease in the ratio of one mental health provider to every 23,250 children. We believe that recruiting 1,000 new mental health practitioners is a reasonable goal over the next several years.

Issue Number Four: The Act calls for two fifths of the recommended new mental health personnel to have training in the field of children's mental health; specifically, 200 of 500. This is inadequate in meeting the unmet needs of Indian children and creates a bigger gap in available services between adults and children.

Recommendation: Amend Sec. 127(1) as follows: change the number 200 to **600.**

Justification: We are recommending that instead of two fifths of new hires having expertise in working with children that three fifth have such expertise. There is already a preponderance of providers working with adults. This disparity in distribution of human resources is higher when one considers that mental health providers working with children and families spend much of their time working with adults. The greater need is to bridge the gap in availability of services for children.

Issue Number Five: Access to psychiatric services is severely limited. This is particularly true for children with multiple diagnoses. This lack of access is further damaging to children suffering from neurological impairments, such as those associated with fetal drug and alcohol disorders.

Recommendation:

- Sec. 701(c)(1) – Add paragraph **"(J) diagnostic services including the utilization of the latest neurological assessment technology**
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- Sec. 703(a) – Add paragraph **"(F) diagnostic services utilizing, when appropriate, neuropsychiatric assessments that use the latest technology of PET (photon emission topography) or SPECT (single photon emission computer topography) scans.**
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- Sec. 703(a) – Add paragraph **"(G) develop and institute a telepsychiatry program drawing upon the experts in the field of pediatric psychiatry, including psychiatrists in assessment, diagnosis and treatment planning for children with concurrent neurological disorders.**

Justification: Indian communities generally have poor and frequently no access to psychiatrists. Access to neuropsychiatrists is even more limited, and access to pediatric neuropsychiatrists is extremely rare. In S.2526, Title VII, Behavioral Health, The Act does not directly address the area of diagnosis, although it does address assessment. It is unrealistic to expect every Indian behavioral health program to have an on-site psychiatrist. With 1,680 U.S. counties lacking these services, many Indian children must have alternatives. A telepsychiatry program would make psychiatric services available to all Indian children. The use of PET or SPECT scans would ensure the high quality of differential diagnosis (MRI's, CAT scans and Xrays show the physical structure of the

brain, while PET and SPECT scans show the ability of the brain to function by mapping activity levels,)

Issue Number Six: Data on Indian children's mental health is scarce and results in obstacles in justifying funding needs, understanding the extent of Indian children's mental health needs and, therefore, developing appropriate strategies.

Recommendation:

- IHS create a task force to assess the current mental health/social services data collection system. This task force would also explore how data from the separate IHS medical data system can contribute to developing an accurate picture of the mental health needs of children and families. The committee would be comprised of members from IHS, tribal leaders, mental health professionals from IHS and tribally run programs, as well as at least one representative from an urban mental health program and at least one representative from an appropriate Indian organization involved in research and/or data collection related to Indian children's mental health.

- All IHS funded programs use the mental health/social services data collection system or provide identified statistics, so that IHS can aggregate them into their data.

- Within the next 12 months IHS be required to produce a report to Congress on status of Indian children's mental health based on data collected per the recommendations of the task force (see first bullet of this set of recommendations) and that IHS disseminate this report to Indian tribes and appropriate organizations.

- Subsequent to the above report, IHS be required to produce a report on the status of Indian children's mental health on a biannual basis.

Justification: Not all IHS funded programs utilize the same data collection systems. Some behavioral health departments are burdened with two systems; one for mental health and social services; the other for substance abuse services. There is considerable confusion regarding how to use these systems when a child is dually diagnosed. In addition, the current mental health/social services data collection system being used by IHS collects information in such a way that obtaining other important information is excluded. Although information regarding age is collected, obtaining meaningful data from IHS does not appear possible. The loss of these data deprives Indian communities and grant writers of the information they need to understand the scope of mental health illness in Indian children. Many individuals who seek medical services are being treated for mental health problems, and services provided by medical health do not get processed into the mental health data collection system. The loss of data through services provided by the medical departments undermines the extent of the problem. This, in turn,

undermines the attempts to justify requests for grants and other funding. Tribes and tribal organizations do need those data that are collected.

CONCLUSIONS

The need for mental health systems of care for Indian children, although inadequately documented, is expected to be substantially higher than that of the general population. Access to services is poor for a variety of reasons including cultural issues, funding, isolation and the need for human resource development. We are recommending that 600 additional mental health practitioners be trained to work with children to address this unmet need.

It is critical that IHS mental health policy keep pace with that of the CMHS and that IHS promotes systems of care within the programs they directly operate, as well as provide technical assistance to tribes and urban organizations running their own behavioral health programs.

We urgently recommend that IHS implement a telepsychiatry program that ensures that Indian children have access to effective diagnostic services. These services must include evaluations from pediatric neuropsychiatrists who have expertise in fetal drug and alcohol disorders and who use PET and SPECT scans in their evaluation.

Data collection and analysis is vital to comprehending the extent of the mental health needs of Indian children, as well as to justify requests for funding and developing intervention strategies. Indian communities have long been hampered by the lack of supporting statistics in their attempts to pursue funding. A task force is recommended to develop an effective data collection system, and a compulsory report would ensure that IHS would acquire and disseminate appropriate data. Follow-up biannual reports would continue to inform Congress and Indian constituents on the status of mental health of Indian children.

The Act carries recommendations through the next decade. The complexity of mental health disorders and solutions to these diseases are just now beginning to be appreciated on a large scale. This Committee has the opportunity to adopt recommendations that would pave the way for substantial cost savings. This Committee also has the opportunity to make a strong statement not only on your commitment to the well being of Indian children but also on your commitment to innovative, effective solutions based in collaboration, partnerships and community ownership of solutions.

Thank you for your attention to this request.

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TESTIMONY FOR THE RECORD
OF CHAIRMAN WAYNE TAYLOR, JR.
SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON S. 2526, TO REAUTHORIZE THE INDIAN
HEALTH CARE IMPROVEMENT ACT
JULY 26, 2000

Thank you, Chairman Campbell, Vice Chairman Inouye, and other distinguished Members of the Senate Committee on Indian Affairs for allowing the Hopi Tribe to provide testimony on S. 2526, legislation to reauthorize the Indian Health Care Improvement Act. We are grateful for your continued attention to improving health care services for all Native Americans.

The Hopi Tribe looks to Congress as the ultimate federal trust authority. Vested in your authority is the ability to ensure the provision of quality health services for all Native Americans. We value your counsel and depend in no small measure on your assistance in establishing an array of health services of critical importance to all Tribes.

I wish to draw your attention to one health care service that has been largely ignored to date in Indian country – the provision of emergency medical transportation services.

Paramedics and Emergency Medical Technicians (EMTs) who provide emergency medical care and transportation to the general population were recognized as an important part of the health delivery system in 1966, with enactment of the Highway Safety Act. The Act provided funding to States to buy ambulances and train EMT-paramedics. States required those involved in the transport of sick or injured people to be certified as emergency medical technicians. Since the mid-1960s, this field has exploded and evolved with medical technology to provide essential front-line medical services as part of the continuum of care. Unfortunately, this critical component in today's health care system is underfunded in Indian country. Tribes are unable to keep pace with health care advances in this field. A growing disparity between comparable care off-reservation is evident and access to health services is impeded.

On the Hopi reservation, providing necessary emergency medical transportation services is a difficult task. Insufficient funding for adequate staffing and outdated equipment leaves our present emergency medical service (EMS) team constantly struggling to provide services. Although the Hopi EMS team performs valiantly, its personnel are stressed for time and lack the equipment necessary to perform certain lifesaving functions. The program lacks the resources to staff the program according to industry standards for the time and distances involved in rural transport.

Unfortunately, the Hopi Tribe witnessed the consequence of insufficient program funding this past April through a tragic incident. A young woman developed a serious condition during her pregnancy. After being brought to the Keams Canyon Hospital for care, physicians determined that she would have to be transported to the Tuba City Indian Hospital (some 84 miles west), a facility more equipped to handle this condition and able to perform surgery not possible at Keams Canyon. As the young woman was being stabilized and readied for transport, another urgent call was received and the ambulance was obligated to transport that patient from the Second Mesa Clinic to the Tuba City Indian Hospital. A second ambulance crew was already attending a local emergency and was committed to remain on the Hopi Reservation. EMS funding is not sufficient to provide for a third "off-duty" or back-up EMS crew -- as industry standards dictate. As a result, the woman was forced to wait for the first available transport – an air ambulance -- several hours later. During this delay, the woman suffered fetal demise (the death of her unborn child) and her own life was placed in extreme jeopardy. This scenario, as well as many others, could possibly have been avoided by providing adequate funding for full staffing of the EMS program, affording a third crew "on duty" or as an "on call" back-up crew.

The current trend of closing hospitals in Indian country and replacing them with ambulatory care centers, or consolidating medical services, places an added burden on emergency medical services teams and elevates the importance of their role in providing necessary transport. With the rural nature of Indian Reservations, miles away from towns and urban centers, transportation is now needed over longer distances for inpatient care, requiring highly trained staff and more advanced equipment. Thus, the system itself is increasing the role of emergency transportation and advanced life support care without providing the necessary financial resources to meet the new need. The end result is a growing gap in the continuum of health care.

We urge the Committee to examine the importance of improving and providing adequate resources for emergency medical transportation services. We recommend that additional funding be provided for the development and maintenance of effective emergency transportation systems through a mechanism included in the reauthorization legislation. The Hopi Tribe views the development and maintenance of emergency medical care systems as part of the trust responsibility in providing essential health and welfare services.

Emergency Medical System Programs Are Important to Providing a Continuum of Health Care Services:

Emergency medical care has become an important part of our health care system, providing a front-line interface with the health care system. Medical ethics dictate certain models of practice to facilitate and insure competent patient care. Previously permitted practices, such as medically unsupervised patient transport or transport supervised by minimally trained individuals for patients with severe conditions, are no longer acceptable practice and are, in fact, illegal. Individuals trained in advanced cardiac care or advanced life support must accompany patients with head injuries, internal hemorrhages, high-risk pregnancies/labor, severe cardiac conditions,

or other life-threatening conditions when the patient is being transported.

Appropriate and expeditious emergency medical care not only means the difference between life and death, but can save substantial expense for the health care system. The health care community has learned in recent years that if appropriate care is administered to injured or sick individuals such as victims of heart attack within minutes of an event, loss of life can be prevented and the chance for full recovery is increased. The administration of expeditious care can save years of rehabilitative costs, lost labor, and other expenses. Injury is one of the leading causes of death among Native Americans. Emergency medical systems must be intact to respond to this public health need.

As the trend toward constructing more ambulatory short-term care centers continues, more hospitals will close. This trend will dictate an increase in emergency and inter-facility transports. It is the job of Congress to ensure the appropriate provision of health services to Native Americans and address this gap in coverage.

Emergency Medical Costs Have Increased Over the Past Two Decades:

Emergency medical costs have increased over the past two decades for the following reasons:

Industry Standards: Standards of care are developed by the industry to keep pace with advances in medicine. Courts often uphold standards of care as a measurement of liability. EMS standards define basic life support (BLS), advanced life support (ALS) and advanced cardiac life support (ACLS) modalities of care, ambulance configuration, dispatch and telecommunications protocol, resource distribution and interagency relations. As technology has improved our medical capacity to deliver state-of-the-art EMS care, standards of care have evolved to incorporate scientific advances in the practice of pre-hospital medical treatment.

Regulatory Bodies: EMS programs must meet many standards to operate as a legitimate health provider. To name a few, EMS programs must follow state and federal Department of Transportation guidelines, federal and state labor standards, federal Medicare standards, state certification and licensing, state or regional medical control/supervision, local permit/licensing, and standards for performance through written agreements.

Service Population Expectations: Americans expect access to high quality EMS services. The daily deluge of television programming demonstrates many of the state-of-the-art uses of emergency medical services. In rural areas where distances are great and the availability of transportation is a serious issue, a responsive and well-equipped EMS service becomes a lifeline upon which the community depends.

Cost of Technology: Technological developments in the delivery of health care services have increased dramatically in recent years. Equipment is highly sophisticated and improved, giving every advantage to saving a patient's life. A three-lead

monitor/defibrillator purchased in 1992 for $12,000 is now obsolete and subject to age-based failure. A twelve-lead monitor/defibrillator sold today can cost more than $20,000 and is essential for meeting "standard of care" treatment for pre-hospital medical care of the cardiac patient.

Cost of Readiness: Crews have to be ready to respond at all times of the day and night. Payment only occurs when actual transports to a medical facility are made. EMS calls that involve treatment rendered at the scene, with no transport, are usually not reimbursed. Similarly, in cases where EMS ground crews administer life saving care at the scene of an accident or other emergency, yet the patient is actually transported to the medical facility by air ambulance, no reimbursement is made.

The Hopi Tribe's Emergency Medical Services Program:

The Hopi Tribe's Emergency Medical Services (Hopi EMS) program is the sole provider of emergency medical services to the Hopi Reservation and parts of the Navajo Reservation in a rural/wilderness response area nearly two million acres in size. They are responsible for responding to emergency calls for all individuals on the Hopi reservation, Indian and non-Indian alike. The Hopi EMS program is contracted under P.L. 96-638 with the Indian Health Service (IHS) to provide 1.5 EMS crews on a 24-hour basis.

The Hopi EMS program employs seventeen full-time and eight part-time EMS personnel certified by the Arizona Department of Health Services. There are ten paramedics, four intermediate emergency medical technicians (IEMTs), and eleven emergency medical technicians-defibrillator basics (EMTs-D basics). EMS staff members are scheduled to work twelve, twenty-four, and thirty-six hour shift segments. Three ambulances of the fleet of five are equipped continuously for response, with two ambulances assigned to "on duty" crews and a third ambulance reserved for "call back" crew readiness should a medical emergency require a third ambulance. The remaining vehicles are available as reserve or replacement ambulances to allow for scheduled maintenance and repair schedules to occur. Technically, the Hopi EMS program only has enough resources to staff 1.5 full-time crews and needs funding for three full-time crews. At present, overtime is used to compensate for lack of personnel. As emergency call volume increases staff overtime, staff burnout results in an area where it is difficult to find experienced EMS personnel.

During the past five years, Hopi EMS has experienced a growth in the volume of emergency calls of about fifty-seven percent (+/- 10% per year). Should this trend continue, Hopi EMS is projecting an annual call volume of nearly 2000 calls by the year 2004. Roughly, half of the calls are EMS 911-emergency calls and half are inter-facility patient transports either to an air-ambulance or by ground directly to another health care facility ninety to one hundred-twenty miles away.

The Hopi Tribe recently opened a new ambulatory health care center. Although the Center offers a wider array of health services, inpatient capacity is extremely limited (4 beds and 2 birthing beds). With the closing of the seventeen bed inpatient hospital,

most patients requiring inpatient care must now be transported depending on their condition and availability of beds at the ambulatory care center. Inter-facility transports are expected to increase dramatically due to facility capacity.

The Hopi EMS program is financed through an IHS PL 93-638 contract agreement, third party billing, and some additional grant funding. The present revenue available for our program is extremely inadequate to meet the mandated mission and serve the population according to basic industry guidelines.

The Hopi Tribe estimates an urgent need of $505,580 to facilitate the move from an inpatient hospital setting to an ambulatory care setting. The expense of operating a standardized EMS program on the Hopi reservation will run a shortfall of $935,000 unless additional revenue is obtained. The attached budget charts will help the Committee understand this shortfall.

Recommendations for Improving the Present Tribal EMS System:

In 1993, the National Highway Traffic Safety Administration, Technical Assistance Team (NHTSA-TAT), conducted an evaluation of the Indian Health Services EMS program. NHTSA-TAT's basic recommendations included the following: 1) that Congress and IHS officially recognize EMS as an integral part of the health care delivery system for Native Americans; 2) that the IHS budget include an EMS line item that dedicates EMS funding consistent with clearly documented EMS needs by 1995; and 3) that IHS establish an adequately staffed EMS branch within the IHS to assure effective oversight, policy development, and support and advocacy for quality EMS services.

The Hopi Tribes suggests that the following steps be considered as a way to address critical EMS needs:

1) Create an IHS/Tribal task force to review tribal EMS programs and assess overall needs. Examine payments from other public payers for such services.

2) Establish a routine reimbursement mechanism for IHS payment of medically necessary inter-facility transports such as from an ambulatory care center to a hospital.

3) Appropriate additional funds to meet the goal of the President's budget request for emergency medical services. The President's budget request for fiscal year 2001 includes an increase of $2,912,000 to "increase access to effective emergency medical services (EMS) for Indian people by improving the capacity of IHS and tribal programs to provide hospital and pre-hospital EMS." The funds are to be available to all IHS Areas and would be used to expand the capacity of the 70 existing EMS programs that now serve Indian people. The budget summary indicates that the funding will include the training of new emergency medical personnel as well as enhancing the skills of current personnel and upgrading equipment. The funding is also to be used to develop EMS capacity for 1 to 3 tribes that are currently without

EMS systems. The budget request notes that presently an estimated **25 tribes have the need to develop EMS systems.** This budget request acknowledges a clear problem.

4) Appropriate additional funds to shore up grant programs administered by the Department of Health and Human Services Office of Rural Health to expand access to health services in rural communities. This Office has supported grants to pilot test the effectiveness of structured treat and release programs; the concept appears to have promise for other rural communities in providing emergency care.

5) Review the Department of Transportation's experience with Tribal EMS programs. Can an initiative be renewed through the Department to provide funding for training and help establish Tribal EMS programs?

6) Consider the attached legislative language drafted by the Phoenix/Tucson/ Navajo IHS Areas during consultations with Tribes on developing reauthorization language for Indian Health Service programs (see attachment).

Conclusion:

In closing, I draw your attention to the remarks of Richard Flores, President of the Southwest Native American EMS Association. Mr. Flores told an audience that he was "struck by the lack of awareness and needs of Native Americans with regard to funding EMS services" during his visit to Washington, DC last year. He advised his audience to address this gap in knowledge, which in turn has created a gap in funding.

Again, thank you for allowing the presentation of this testimony. We look forward to working with you in the course of your deliberations on legislation to reauthorize and improve health programs for Native Americans. I would be pleased to respond fully to any request for additional information and hope you take a serious look at the ever-increasing need for improved emergency medical services.

Attachment A

HOPI EMERGENCY MEDICAL SERVICES

P.O. BOX 98, KEAMS CANYON, ARIZONA 86034 TEL: 520-738-2211 x 195 – FAX 520-738-5442

FUNDING REQUEST – HHCC TRANSITION - EMERGENCY MEDICAL SERVICES

Hopi EMS respectfully requests an urgent consideration of the following budget requests to be included in the FY 2000 funding of PL 93-638 contract #247-97-0019. Consideration for transition costs incurred by the Hopi Tribe upon accepting the Hopi Health Care Center included in the document "18 Requirements" provision of additional funding for medical transportation. To date, no financial accommodation of this urgent need has been made. Additional costs associated with this transition to the Hopi Health Care Center have been incurred already, the transition to the center is scheduled for the month of June 2000. Your attention to this matter is of the utmost importance to the health and welfare of the Hopi people, their neighbors, and their visitors.

TRANSITION FUNDING — AMOUNT: $ 505,580.00

PRIORITY ONE:

P/C	ITEM	JUSTIFICATION	QUAN.	BEACH	TOTAL
1	ADDITIONAL STAFFING	TO ACCOMMODATE ADDITIONAL STAFFING REQUIREMENTS FOR MEDICAL TRANSPORTATION NEEDS AT THE HHCC FOR JUNE THROUGH DECEMBER 2000 OR 7/12 OF FY 2000 ($294,845.00 ANNUALLY)	NINE EMS CREW MEMBERS 3-CIP 3-EMT 3-EMT-D OVERTIME BENEFITS	$ 180,180.00 53,000.00 46,000.00 39,005.00 3,000.00 32,180.00	$ 180,180.00
2	638-VEHICLE LEASE	ESTIMATED LEASING COSTS FOR FOUR AMBULANCES, ONE RESCUE TRUCK, AND ONE ADMINISTRATIVE VEHICLE(FOR 7/12 OF FY2000 ($60,000.00 ANNUALLY)	SIX VEHICLES	$ 35,000.00	$ 35,000.00
3	LAB-MEDICAL SUPPLIES	FUNDING TO ACQUIRE INITIAL STOCK REQUIRED FOR NEW TERMS OF AGREEMENT WITH PL 3-638 CONTRACT 7/12 OF FY 2000 ($73,000.00 ANNUALLY)	7 MONTHS	$ 6,000.00	$ 43,000.00
4	CAPITAL EQUIPMENT – (2) 12 LEAD CARDIAC MONITOR DEFIBRILLATORS	THE STANDARD OF CARE FOR THIS REGION INCLUDES THE USE OF 12 LEAD CARDIAC MONITORING. THESE ITEMS WILL BE PLACED ON AMBULANCES AND USED IN THE PREHOSPITAL SETTING BY PARAMEDIC STAFF.	TWO UNITS	$ 28,000.00	$ 56,000.00
X X	TOTAL PRIORITY ONE	MINIMUM FUNDING TO MAINTAIN SERVICE AVAILABILITY FOR FY2000/HHCC TRANSITION	7 MONTHS	$ 30,740.00	$ 313,180.00

PRIORITY TWO:

P/C	ITEM	JUSTIFICATION	QUAN.	BEACH	TOTAL
5	RADIO SYSTEM MOBILE, BASE, PORTABLES, PAGERS	U.S. GOVERNMENT DOI – BIA IS MANDATING THAT ALL AGENCIES COMMUNICATING ON BIA FREQUENCIES MUST CONVERT RADIO SYSTEMS TO MEET "PROJECT 25" REQUIREMENTS. HOPI EMS	3-BASE STN 4-REPTRS 14-MOBILE 12-PORTAB 35-PAGERS	$ 3,333.00 1,800.00 2,300.00 1,400.00 400.00	$ 9,600.00 7,200.00 32,000.00 16,800.00 14,000.00

		RELIES ON FEDERAL FREQUENCIES FOR DISPATCH AND INTERAGENCY COMMUNICATIONS—NOT COMPLYING TO MANDATE MAY JEAPORDIZE PATIENTS AND EMERGENCY SERVICE PERSONNEL	4-TOWERS	3,600.00	14,400.00
	INSTALLATION		COMPLETE SYSTEM	$ 11,500.00	11,500.00
	TOTAL COST	.....	.....	.....	$ 194,900.00
6	CAPITAL EQUIPMENT – (1) 12 LEAD CARDIAC MONITOR DEFIBRILLATOR	THIRD 12 LEAD CARDIAC MONITOR-DEFIBRILLATOR IS USED AS BACK-UP UNIT AND WILL ALLOW FOR THIRD PARAMEDIC UNIT TO BE DISPATCHED WHEN NEED OCCURS.	ONE UNIT	$ 28,000.00	$ 28,000.00
7	SATELLITE/CELL PHONE SYSTEM	PHONE SYSTEM IS NEEDED TO COMPLETE THE COMMUNICATION SYSTEM TO ALLOW FOR EKG TRANSMISSION, REDUNDANCY FOR MEDICAL CONTROL, AND PERMIT FUTURE DEVELOPMENT OF TELEMEDICAL TECHNOLOGIES.	5 – MOBILE 2-PORTABL INSTALL:	$ 4,000.00 3,500.00	$ 20,000.00 7,000.00 2,500.00 $ 29,500.00
8	LAB-MEDICAL SUPPLIES	NEEDED TO ACQUIRE RESERVE MEDICAL SUPPLIES FOR RESIDUAL AND DISASTER PREPAREDNESS	5 MONTHS	$ 6,000.00	$ 30,000.00
X x	TOTAL PRIORITY TWO	REQUIRED FUNDING TO MEET FEDERAL MANDATES AND SYSTEM DEVELOPMENT REQUIREMENTS			$ 192,400.00

PRIORITY ONE:	**$ 313,180.00**
PRIORITY TWO	**192,400.00**
TOTAL REQUEST	**$ 506,580.00**

Attachment B

HOPI EMERGENCY MEDICAL SERVICES

YEAR 2001 BUDGET SUMMARY

LINE ITEMS	CREW 1	CREW 2	CREW 3	EMS ADM	IHS-639	OTHER	TOTAL	SHORTFALL
SALARIES	253,000.00	253,000.00	253,000.00	92,000.00	351,696.00	54,068.00	851,000.00	445,248.00
OVERTIME	12,000.00	12,000.00	12,000.00	3,000.00	12,000.00	15,000.00	39,000.00	12,000.00
PT-TEMP	20,000.00	20,000.00	20,000.00	6,000.00	-	15,000.00	66,000.00	51,000.00
BENEFITS	79,800.00	79,800.00	79,800.00	28,280.00	101,832.08	23,539.04	287,680.00	142,308.88
TRAVEL/TRNG				40,000.00	-	10,000.00	40,000.00	30,000.00
OFFICE SUPPLIES				10,000.00		2,500.00	10,000.00	7,500.00
PRINTING				4,500.00		2,400.00	4,500.00	2,100.00
GEN.OPERATING				15,000.00		1,500.00	15,000.00	13,500.00
FUEL-OIL-LUBE				12,000.00		4,000.00	12,000.00	8,000.00
CLOTHING				8,800.00		4,000.00	8,800.00	4,800.00
LAB-MEDICAL				25,000.00		5,000.00	25,000.00	20,000.00
OTHER SUPPLIES				9,800.00		2,500.00	9,800.00	7,100.00
UTILITIES				12,000.00		200.00	12,000.00	11,800.00
GARBAGE				600.00		200.00	600.00	400.00
TELEPHONE				3,600.00		2,400.00	3,800.00	1,200.00
EQUIP RENTAL				6,000.00		100.00	6,000.00	5,900.00
SPACE COST				25,000.00		100.00	25,000.00	24,900.00
VEHICLE LEASE				60,000.00		28,000.00	60,000.00	32,000.00
VEHICLE MAINT.				24,000.00		1,000.00	24,000.00	23,000.00
EQUIP.MAINT.				10,400.00		500.00	10,400.00	9,900.00
CONSULT.PROF.				6,000.00		4,500.00	6,000.00	1,500.00
DUES&SUBSC				600.00		236.00	600.00	364.00
INSURANCE				10,400.00		500.00	10,400.00	9,900.00
VEHICLE PURCH.				35,000.00		5,000.00	35,000.00	30,000.00
FURN. & EQPMT				42,208.12		7,500.00	42,208.12	34,708.12
MISC./CONTING.				10,000.00		4,127.00	10,000.00	5,873.00
TOTAL OPERA	364,800.00	364,800.00	364,800.00	499,988.12	465,518.08	193,870.04	1,694,388.12	935,000.00
CURRENT &	364,800.00	100,718.08	-	193,870.04	465,518.08	193,870.04	659,388.12	935,000.00
REQUESTED	-	264,081.92	364,800.00	306,118.08	-	-	xxxxxxxxxxxxxx	935,000.00

Attachment C

Proposed/Recommended changes to the 437 Reauthorization Legislation related to

Emergency Medical Services

Title II – Health Services

SEC. XXX. (a) The Secretary, acting through the Service, shall provide a specific Indian Emergency Medical Services (EMS) Program that will minimally consist of :

(1) The budget line item appropriation shall be administered by the Secretary, acting through the central office of the Service, solely for the purpose of meeting the extraordinary medical costs associated with the provision of a comprehensive emergency medical service programs to American Indian/Alaskan Native communities.

(2) The appropriation shall cover the provision of ambulances appropriate for the service location, terrain, and level of staff licensure; replacement, repair and maintenance of ambulances are covered within each appropriation.

(3) Staffing and equipment shall be according to national standards and state statues applying to EMS services, of at least–

(a) Three hundred fifty (350) to four hundred (400) ambulance calls would establish the eligibility for a paid EMS staff rather than a volunteer staff using one vehicle with 24 hour coverage.
(b) Each ambulance would be staffed with nine (9) EMS direct care FTE providers and 1.5 administrative FTE.
(c) Number of staff FTEs and equipment will be determined by a national standard need formula based on demonstrated utilization community and health care system need. The results of this formula will determine base funding allocations by program/community.
(d) There shall not be any duplication of EMS services, i.e. competing services for the same Tribal community, funded by this appropriation.

(4) After employment of qualified EMS direct care staff, training costs to renew and/or upgrade EMS staff licensure will be paid by the appropriation of specific funds within this section.

(5) The appropriation line item for Emergency Medical Services shall be within the Hospital and Clinics section of the total Service and cannot be diverted to other health care needs.

(b) The Service shall report to Congress annually on the impact of these Emergency Medical Service appropriations within the American Indian/Alaskan Native communities benefiting from the appropriation.

Muscogee (Creek) Nation

PRINCIPAL CHIEF
R. Perry Beaver
SECOND CHIEF
A.D. Ellis

OFFICE OF THE PRINCIPAL CHIEF
PO Box 580
(HWY 75, Loop 56)
Okmulgee, Ok 74447
918/756-8700

July 26, 2000

The Honorable Ben Nighthorse Campbell, Chairman
Senate Committee on Indian Affairs
838 Hart Senate Office Bldg.
Washington, D.C. 20515

RE: S. 2526, Section 512 (a) and (b)

Dear Chairman,

In reference to the possible amendment of S. 2526, Section 512 of the proposed measure, (to permanently authorize two ongoing demonstration projects in Oklahoma), we are requesting a hearing on Section 512.

The projects in question are funded through Indian Health Service to provide services in Oklahoma City and Tulsa for the benefit of two independently organized groups of urban based citizens who have no direct relationship to any of the Tribes in Oklahoma, Texas or Kansas.

The Indian tribes of Oklahoma, Kansas and Texas have enjoyed long-term support from their respective Congressional Offices since the enactment of P.L. 93-638, (Indian Self-Determination and Education Assistance Act). This proposed action sets a precedent that is contrary to Self-Determination and Self-Governance for Indian tribes, as well as the intent of all other legislation concerning services for Indian people. As you are aware, services and resources to support those services are tied to federally recognized tribes that have a reservation land base or a previously defined land base, which is a result of individual treaties between tribes and the United States.

The demonstration authorization of funding for Indian Health Service resources, outside the responsibility of the tribes, established the precedent that any group of Indian citizens or individual Indians can have Congress set them up in business independently without honoring the federal/tribal government-to-government relationship. While the two demonstration projects in Oklahoma City and Tulsa have been addressing health care needs, they are clearly absent of any input/or participation of the tribal governments which are authorized to represent the Indian citizens to whom they are providing services.

If these demonstration project clinics are permanent, all Indian Nations in Oklahoma, Kansas, Texas are concerned that your actions would be contrary to existing Self-Determination principles. ***We are requesting field hearings on this issue during the August recess or at a time more convenient before the next Congress convenes.*** ***Attached is proposed language on this issue.***

Sincerely,

R. Perry Beaver, Principal Chief
Muscogee (Creek) Nation

REVISED LANGUAGE PROPOSED TO S. 2526, SECTION 512 (a) OKLAHOMA CITY CLINIC

The Oklahoma City Urban Clinic shall be subject to the authority of Public Law 93-638. Thus, the Oklahoma City Urban Clinic shall be contractible or compactable under the provisions of that law. The Oklahoma City Urban Clinic shall be contractible or compactable only under the auspices of those seven (7) Tribes with historic boundaries surrounding the Oklahoma City area. Those Tribes include: Citizen Potawatomi Nation, Absentee Shawnee Tribe, Iowa Tribe of Oklahoma, Kickapoo Tribe of Oklahoma, Sac and Fox Nation, Cheyenne-Arapaho Tribe and Chickasaw Nation.

The Oklahoma City Urban Clinic shall only be contracted or compacted under P.L. 93-638 through resolution provided to any of the seven affected Tribes, by consensus or by a simple majority (4) of the affected Tribes, or to a consortium of those seven Tribes. It shall be understood that all citizens (users) of the Oklahoma City Urban Clinic shall remain harmless during this process.

REVISED LANGUAGE PROPOSED TO S. 2526, SECTION 512 (b) TULSA CLINIC

The Tulsa Urban Resource Center, Indian Health Clinic, shall be subject to the authority of Public Law 93-638. Thus, the Tulsa Urban Resource Center shall be contractible or compactable under the provisions of that law. The Tulsa Urban Resource Center shall be contractible or compactable only under the auspices of two (2) Tribes with historic boundaries in the Tulsa City area. Those Tribes include: Cherokee Nation of Oklahoma and Muscogee (Creek) Nation.

The Tulsa Urban Resource Center shall only be contracted or compacted under P.L. 93-638 through resolution provided by the two affected Tribes. It shall be understood that all citizens (users) of the Tulsa Urban Resource Center shall remain harmless during this process.

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LEGISLATIVE AFFAIRS:
KAREN J. FUNK
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MARIE OSCEOLA-BRANCH

August 14, 2000

Honorable Ben Nighthorse Campbell
Senate Committee on Indian Affairs
Room 838 Senate Hart Building
United States Senate
Washington, DC 20510

RE: S. 2526

Dear Chairman Campbell:

We write on behalf of the Bristol Bay Area Health Corporation to make clear its position on a provision in S. 2526. Section 406(g) of the bill permits tribal health care programs funded under the Indian Self-Determination and Education Assistance Act to recover reimbursement for health services provided to employees of Indian tribes or tribal organizations from tribally self-insured employee health plans only with the consent of the tribal employer.

This additional provision was not included in the bill as recommended by the National Indian Steering Committee. We participated actively as a representative of BBAHC in the many national and regional consultations which produced the Steering Committee draft. To our recollection no tribal representative every proposed such a provision. Our client is not aware of any tribe or tribal organization which had recommended this change in the bill.

We also participated in the development of testimony for the hearing on July 26 to be submitted by the Steering Committee. At that meeting it was determined that the Steering Committee would recommend the deletion of this provision in section 406(g) since that Steering Committee was not aware of any tribal support for the provision and considerable tribal opposition had been voiced.

We understand that, while no Steering Committee representative was asked to testify on Title IV at the July 26 hearing, a statement has been prepared, including a recommendation for the deletion of this provision, but that it was not cleared in time for submittal prior to the deadline last Friday, August 11.

While we have been assured that this Steering Committee statement will be filed for the record of the recent hearing in Bismarck, North Dakota, on the bill, we are submitting this letter on behalf of our client, the Bristol Bay Area Health Corporation, in order to assure that its position is reflected in the record. BBAHC provides health services in the 45,000 square mile Bristol Bay region of Alaska, and operates the Kanakanak Hospital in Dillingham, Alaska. It depends for tertiary in-patient care on the Alaska Native Medical Center which is now operated under the Indian Self-Determination and Education Assistance Act by the Alaska Native Tribal Health Consortium, a coalition of tribes and tribal organizations which includes BBAHC and its member tribes. In BBAHC's view, the ability to recover for health services provided to Indian and Alaska Native employees of tribal organizations which self-insure as allowed by existing law and the Steering Committee bill is critical for the financial viability of the ANMC. BBAHC urges that your Committee follow the Steering Committee recommendations with respect to the wording of section 406(g).

We respectfully request that this letter be included in the record of the hearing on July 26 and express our appreciation in advance for your willingness to do so.

Sincerely yours,

HOBBS, STRAUS, DEAN & WALKER, LLP

By: S. Bobo Dean

cc: Senator Inouye, Attn: Patricia Zell
Senator Stevens, Attn. Elizabeth Connell
Senator Murkowski, Attn: Amy Bannon
Congressman Don Young, Attn: Cynthia Ahwinona
H. Sally Smith
Robert Clark
Rachael Joseph
Buford Rollin
Myra Munson

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Kalispel Tribe
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Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshoni Tribe
Port Gamble S'Klallam Tribe
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Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
Yakama Nation

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July 26, 2000

Senator Ben Nighthorse Campbell and Senator Daniel Inouye,
Senate Indian Affairs Committee
Hart Senate Office Building
Washington, DC 20510

Dear Senators Campbell and Inouye,

Thank you for this opportunity to provide testimony on the Indian Health Care Improvement Act. Tribes nationwide appreciate your efforts in holding the Senate Indian Affairs Committee's third hearing on proposals to amend and reauthorize P.L. 94-437. I was privileged to testify in person at the May 10, 2000 hearing where I was asked to comment on Title III, the facilities title. I would like to limit my comments today to Title IV, the Access to Health Services Title of the Indian Health Care Improvement Act.

The Northwest Portland Area Indian Health Board has been an active participant in both the current law (P.L. 94-437) provisions relating to Medicare and Medicaid contained in Title IV and the proposed changes reflected in Senate Bill S. 2526.

The purpose of Title IV is to allow American Indians and Alaska Natives full access to the health programs administered by the Health Care Financing Administration. As you know these programs include the Medicare, Medicaid and Children's Health Insurance Programs. In addition, Title IV grants authority to Indian health programs to bill and be reimbursed for services provided to eligible American Indians and Alaska Natives.

Title IV is a complex title that addresses issues fully understood by only a handful of health policy experts. The National Steering Committee benefited from the work of many Indian Health Service, tribal, urban and Health Care Financing Administration staff and tribal attorneys in the development of the proposed Title IV in S. 2526. Yet amidst this complexity, the title really has only two goals: First, to guarantee Indian people access to the Health Care Financing Administration's programs and secondly, to ensure that Indian health programs are paid for services provided to eligible American Indians and Alaska Natives (and in certain instance other non-Indian patients).

Of course, beyond the two related goals of the title lies the complexity of the programs themselves and their interaction with an equally complex Indian health system of health care delivery and finance. Consider how Medicaid, a means-tested health insurance program, financed jointly by states and the federal government, but administered by states according to federal policies interacts with the Indian Health Care system. First, imagine how one of my

Nez Perce Indian elders feels when being interviewed about her finances as a condition of receiving her contract health care-purchased services. It is required that we do so by Indian Health Service policy and as a practical matter to increase our revenues. Second, you can imagine how a tribal leader reacts when told that a shift in state of Idaho policy can mean fewer rather than more dollars in income from Medicaid. In both cases the sense that a federal obligation to our tribe has been violated leaves our people confused and questioning why do leaders like myself continue to work on Medicaid issues. I ask the same question myself and continue to advocate for entitlement status for Indian health, but I know that we must, for the time being, improve our relationship with the Health Care Financing Administration programs. That is what we have tried to do in Title IV.

The Northwest Portland Area Indian Health Board and its member tribes have a great deal of experience with Medicaid and the much smaller Children's Health Insurance Program. In fact, last June we were invited by the National Steering Committee to share our experience in a presentation to the committee that detailed current Medicaid practices in our states of Oregon, Washington, and Idaho. That presentation listed many of our existing practices that became the new amendments to the act to promote access to Health Care Financing Administration programs and guarantee payment to Indian health programs. These practices were established with hard-fought negotiations in our states with Medicaid programs and the Health Care Financing Administration. The practices include: exemptions from estate recovery, exemption from cost sharing, prohibition of automatic assignment to non-Indian providers or managed care plans, payment for out-of-plan services when an American Indian does choose a managed care plan as their primary provider, payment of the federal all-inclusive encounter rate for services such as dental, mental health and alcohol and substance abuse treatment, payment (and reimbursement to states at the 100% Federal Medical Assistance Percentage) for services beyond the four walls of our facilities, and other important agreements that all share the goal of increasing access to American Indians and Alaska Natives and guaranteeing fair payment to Indian health programs.

Let me repeat that these Medicaid practices are examples of our accomplishments under the current act. Why then did we work to include changes in the reauthorization bill? The answer is because tribes in other areas told our tribes that our accomplishments were good ones, but in most cases not achievable in their states. We were asked to document our practices and work to codify them in the reauthorization bill together with other model practices in states such as Alaska. By placing them in the new Indian Health Care Improvement Act these practices will not depend on the whim of state politics or changes in views of the Health Care Financing Administration. Our own self-interest also makes us a strong a supporter of these changes because we know these practices are successful but we also

know the political support behind them is tenuous. All tribes, including our own, will benefit from making permanent law what is now simply a matter of policy.

Finally, proposed changes to the Medicare program will correct the disgraceful record of this program in serving Indian people. In my view, the authority for Indian Health Service clinics to bill Medicare should not have to wait for the bill to pass. Couldn't this change be made in a technical amendment to some other bill or report language for the Interior Appropriations bill (HR 4578)?

I would also hope that the committee continues to work for the elevation of the Indian Health Service Director to Assistant Secretary for Indian Health in the Department of Health and Human Services rather than wait for this change to take place as a new provision of Title VI.

Thank you again for the opportunity to share our views with the committee. The Northwest Portland Area Indian Health Board continues to keep our member tribes informed on the progress of the Indian Health Care Improvement Act and we stand ready to assist the committee until the reauthorization bill is passed. If you have any questions please contact me or our staff for the act, Ed Fox at 503-228-4185.

Sincerely,

Ed Fox for J.A.D.

Julia A. Davis

Albuquerque Metro Native American Coalition (AMNAC)
P.O. Box 1571
Albuquerque, New Mexico, 87103
Phone: (505) 291-1880
e-mail: mokohoko@aol.com

July 19, 2000

The Honorable Pete Domenici
U.S. Senator
328 Hart Senate Office Building
Washington, DC 20510

Dear Senator Domenici:

I am appealing for congressional attention and interest to the diminishment of services of the Indian Health Service (IHS), Albuquerque Servicing Unit (ASU) and the imminent closure of the IHS, Southwest Indian Polytechnic Institute (SIPI) Dental Program.

Health care for the 30,000 Urban Indians living in Albuquerque is a dismal reflection of the commitment that the United States government brings to its trust responsibility. The primary federal agency that has responsibility for the provision of health care for Native Americans and Alaska Natives is the Indian Health Service, which is part of the U.S. Department of Health and Human Services. The Albuquerque Service Unit, which is a part of the Albuquerque IHS Area Headquarters is located in the city and has been delivering health care services and programs to the 27 tribes in the area as well as the urban Indian population. However, in the past six years, there has been a steady and surreptitious erosion of services to the urban Indian population by the IHS. This has occurred through a series of funding management problems, diversion of funds to other than patient care priorities, avoiding the health care needs of the urban Indians by abolishing approximately 16 health care positions and mainly the local tribes exercising greater self-determination over their health service to bring the delivery systems to their home communities.

The Albuquerque urban Indians have no quarrel with the local tribal governments exercising greater self-determination, in fact, we encourage it. However the latest withdrawal of the "tribal-funding shares" in FY 2001 will force closure of the SIPI/IHS Dental Clinic. Moreover, it will leave the majority of Native Americans residing in Albuquerque without even the most basic dental services to relieve pain and suffering, let alone broader service to maintain sound dental health. Compounding our concerns is that out of approximately 5,000 Indian students enrolled in the Albuquerque school districts, only 1,073 received SIPI/IHS Dental Clinic services in 1998. Albuquerque children not using dental services is an unbelievable 79%! Again, this reverts back to the lack of funds to reach the American Dental Association recommended ratio of 1 dentist per 2,000 population. SIPI/IHS Dental Clinic's ratio of full time dentists is 1 to 30,000.

There does not appear to be any real commitment from the Indian Health Service to improve or restore health care services to the urban Indians in Albuquerque except to engage in lengthy discussions and rhetoric about "partnerships" which have been going on for over 2 years. There has been no attempt by IHS to request additional appropriation for this large group of Native Americans. (The Indian Health Service reports that, although over 65% of Native Americans live in an urban setting, less that 1% of the IHS budget is distributed for their care.) In the meantime, the health care "rug" is slowly and assuredly being cut away from people who can least afford to pay for health care.

The Albuquerque urban Indian population numbers have been used to justify the budget for the Albuquerque Service Unit and then the tribal entities in the ASU catchment area are permitted to divide up the "urban-inflated" funding utilizing the tribal population as a percentage of the whole budget without considering that the tribal user population (13,134) is not accurately represented in terms of percentage of the whole Native American population served. The 1997 IHS service statistics show that of the 85,854 visits to IHS facilities, urban Indians made 72,720 of those visits generating over $13.4 million of the $16.6 million recurring dollar distribution to the local ASU tribes. Without the urban Indian service population numbers, the amount of the whole budget would be smaller ($3.2 million vs $16.6 million) and therefore, the tribal shares would be smaller. The urban Indian population receives zero dollars of $16.6 million distribution. **If Albuquerque urban Indians were counted as part of the total service population that IHS cited when collecting Snyder Act Funds from Congress, the Albuquerque urban Indians should also be recipients of the equitable division of those funds. (Reference Rincon Band of Mission Indians v. Califano, 464 F. Supp 934 (N.D. cal. 1979)**

I am asking for your assistance to make an congressional inquiry into why IHS couldn't change the status of the SIPI Dental clinic back to its original charter as an all nations dental clinic for the purposes of establishing a dental training facility and a dental service clinic for the 30,000 urban Indian population which includes over 5,550 SIPI, Albuquerque Public Schools and University of New Mexico students. This request is not asking for a unique situation, the Haskell Indian Nations University (formally Haskell Institute) has an all nations health and dental clinic which dates back beyond 1950's and has direct funding that is not subservient to the local tribes and is not under the auspices of P.L. 93-638.

I am also requesting that during the Senate hearing on the rewrite of P.L. 94-437 you consider introducing this written testimony from Albuquerque Indian community. Because this group feels so strongly that the trust responsibility is being violated and that accountability and responsibility is not being taken seriously by the IHS, we are asking that amendments to the P.L. 94-437 include references to urban Indian communities such as Albuquerque ensuring funding for that group in the future. Except for Title V under P.L. 94-437, urban Indian communities do not have direct access to the funding provided to existing Indian Health Services facilities in urban areas. Title V also only provides funding directly to urban Indian organizations and not to existing urban IHS facilities. Urban Indians, especially in Albuquerque, desire to continue to obtain their health care through existing IHS facilities.

It is imperative that intense congressional attention be made to the urban Indian health issues in Albuquerque and to the methods that the IHS utilizes in addressing and funding the health care needs of this large population.

Specifically I request that you support legislation to appropriate supplemental recurring funds be introduced and passed to support the SIPI Dental Program as a federally staffed program at the 1994 level of service (for the next 3 fiscal years) which is approximately $2.7 million dollars annually. It is imperative that such appropriations for the SIPI Dental Program be dedicated, line-item budgets for the urban Indian populations and be treated as a service unit in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination and Education Assistance. There should also be periodic reports required of the IHS to appropriate congressional groups to assure the integrity of such expenditures.

I would appreciate you making this letter a part of the hearing record before the Senate committee hearing on P.L. 94-437 rewrite and the Senate Appropriations subcommittee.

Your continued interest and support is greatly appreciated. Feel free to contact Emmett Francis at (505-768-3000) or Keith Franklin at (505) 291-1880 regarding this matter. Thank you very much.

Sincerely,

Keith E. Franklin

Keith E. Franklin, Chairman

CHEYENNE RIVER TRIBAL NATION POSITION PAPER

ON THE REAUTHORIZATION AND REVISIONS

TO THE INDIAN HEALTH CARE IMPROVEMENT ACT

The reauthorization of this legislation is essential to the efforts of all Tribal Nations to continue the process of improving the health care of our Tribal members.

To briefly summarize, we strongly support the Government-to-Government Consultation process and the proposed amendments. We strongly urge Congress to increase appropriations to a level consistent with that provided to the nation as a whole and would hope Congress will see fit to fund those sections that have been authorized but never funded.

In these times of prosperity, it is heartbreaking to watch our people continue to suffer from diseases whose rates can only be compared to those of some of the more disease ravaged Third World Countries. In this period of extended budget surpluses, we urge Congress to utilize a portion of this surplus to raise the level of funding for Indian Health programs which in this area are funded at less than 50% of the known unmet needs. This results in suffering and early death for many tribal members. We feel the Indian Health Service goal of "Raising the Health Status of the Indian people to the highest level" is innocuous and should be more specific i.e. "at least to the same level as the health status enjoyed by the rest of the nation".

The IHCIA along with the Snyder Act is the legislation at the core of the Federal Government's responsibility for meeting the health needs of AI/AN. Since this legislation contains a wide ranging list of provisions, many of which have significant budget and management implications across Indian Country, a thorough review and careful consideration are necessary to ensure continued improvement of Indian health care. Specifically we will address each title individually as it relates to issues that affect the daily lives of our Tribal members and impacts upon their health and welfare.

TITLE I - INDIAN HEALTH HUMAN RESOURCES AND DEVELOPMENT

We certainly support the two-fold purpose of this title:

1.) To increase the number of Indian students entering the health professions; and,

2.) To assure an adequate supply of health professionals to the Indian Health Service and to Urban and Tribal Health delivery systems.

Of particular interest is new language added in section 116 to require that "appropriate employees" undergo instruction in the culture and history of the Tribe whose members they provide services to, which would be provided by tribal colleges, if possible. The cultural sensitivity training may be more appropriately provided by Tribal Councils. This should greatly reduce staff turn over amongst non-member medical staff.

We would support language to require Title I recipients to fulfill their scholarship and job placement requirements in the areas from which they receive their scholarship assistance.

We also strongly support language that would designate all programs operated by Tribes as health profession shortage areas. Tribal Health profession staffing needs must be given consideration on an equal basis with programs operated by the Indian Health Service. There should be no change for those students already in the "pipeline" regarding their priority status.

TITLE II - HEALTH SERVICES:

We fully support the goals of Section 201, which would reinstitute the Indian Health Care Improvement Fund. Section 201, "(a)" (5) Augmenting the Ability of the Services to meet the following health service responsibilities with respect to those Indian Tribes with the worst level of health status and resource deficiencies in the following categories:

(A) Clinical Care

(B) Preventive Health

(C) Dental Care

(D) Mental Health

(E) Emergency Medical Services

(F) Treatment and Control of/and rehabilitative care related to alcohol and drug abuse.

This must surely have been written specifically for the "Aberdeen Area" in general and each of the Tribal Nations in this area in particular. Unfortunately, the Aberdeen Area Indian Health Service and Tribal Health patients suffer from the worst health status and have the greatest resource deficiencies in the nation. It is estimated this area is funded at 47% of the amount the Indian Health Service calculates as the resources needed to fund

100% of the Area's known health needs. It seems so unconscionable that as we enter the twenty- first century in a nation with unprecedented prosperity that Native Americans continue to be afflicted by disease at rates much greater than other races; they continue to suffer more and longer; and many die decades earlier than they should because they lack access to health care that is adequate.

Year after year studies have revealed that prevelance of Diabetes amongst Indian people has increased at an alarming rate. Type II (Onset) Diabetes is epidemic amongst younger tribal members. Recently a thirteen (13) year old female member was diagnosed with Type II Diabetes. On average, three (3) additional tribal members are diagnosed per week with Type II Diabetes. It is believed that many, many more are in a state of denial. Complications of this dreaded disease continue to devastate many members of our Tribal Nations.

Historically, Diabetes was unheard of in Indian Country, before we were subjected to an abrupt change in our lifestyle. We were the healthiest people on Earth. We were highly mobile, subsisting on a diet rich in protein and low in carbohydrates.

Studies have indicated our Indian bodies react differently to carbohydrates, fats and sugars. Therefore, research done on the effects of Diabetes on Indian people must be conducted on Indian people to have meaningful results.

We strongly support the goals of Section 204 that would make model Diabetes programs recurring through the Year 2012. We urge Congress and the Administration to be generous with resources to implement this section in a meaningful way to prevent and control Diabetes.

The Cheyenne River Sioux Tribal Nation strongly supports the revision to Section 204 which includes Authority for funding to establish, equip and staff kidney Dialysis programs to treat the burgeoning number of diabetics suffering from renal failure.

This area continues to receive less than its equitable share of Indian Health Service funds because of the capitation based funding formula adopted by Indian Health Service Headquarters. A capitation-based distribution formula penalizes us because of the high percapita usage of health services in the Aberdeen Area. To correct this inequity, we strongly encourage language that would mandate the usage of weighted health status; particularly, years of productive life lost (YPLL) by Indian Health Service. We strongly recommend that area offices consult with local Tribal Nations regarding fund distribution rather than relying upon the central office to make the distribution on their behalf.

We strongly support the expanded services in Section 213 to include hospice care, assisted living, long-term health care and traditional health care.

The Cheyenne River Sioux Tribal Nation operates the only EMS services within a 50 mile radius. The program is seriously under funded as the primary link to our outlying communities for patients with emergency health care needs. This constitutes a serious breach in our health delivery system. Therefore, we urge Congress to appropriate sufficient EMS funding as a recurring line item in the budget.

We support all other sections of Title II and urge Congress to fund the appropriate sections in a meaningful way.

The Cheyenne River Sioux Tribe opposes the current Indian Health Service Contract Health Care Priority System as being neither economically sound nor conducive to the provision of quality health care. The Cheyenne River Sioux Tribal Nation urges Congress to establish a committee which includes consumers to research the devastating affect this priority system is having on the ability of our patients to access health care at the most appropriate time to insure the most desirable medical outcome in the most cost effective way.

TITLE III - FACILITIES:

We appreciate Congress' commitment to continue to expend funds for the planning, design, construction and renovation of health facilities on behalf of Tribal Nations.

The Cheyenne River Sioux Tribal Nation, along with others in this area, is in dire need of expanded health care facilities with sufficient staff to meet the current demands for outpatient and inpatient services. Limited health care capabilities of our local facility together with limited Contract Health Care dollars leaves many patients with no access to health care for extended periods of time. This phenomenon results in needless patient suffering and premature death in many cases.

We support the various sections of Title III including the requirement for Tribal Consultation in all facility issues and the language encouraging Tribal Nations to become creative and innovative in their approach to facility construction. To further enhance this

section, we urge Congress to support the design and construction of inpatient facilities under the Joint Venture Health Facilities Demonstration program.

With regard to the establishment of a facility priority system by the Secretary, we recommend the establishment of a base-funding amount to ensure the completion of those facilities that have gone through the process of review and approval. It is our position that because many Tribal Governments have spent years getting their project on the list, it would be unfair to those Tribes to amend the priority system at this time.
It is also our position that greater emphasis should be given to unmet health needs and health status and more weight placed on remoteness in establishing a health care facility priority list.

We also urge Congress to consider the total need of all Tribal Nations when determining facility needs even though those with critical needs may exceed ten in any one of the stated categories. Congress should adopt this policy initially until the playing field is leveled before placing a limit on the number of facilities it will consider for funding in each category in each reporting period.

TITLE IV - ACCESS TO HEALTH SERVICES:

We support the provisions in this title that attempt to eliminate barriers which prevent Indian Health Service, Tribal Nations and Urban organizations from fully accessing reimbursement from other Federal Programs including Medicaid, Medicare and Children's Health Insurance Program (CHIP).

Severe and longstanding lack of adequate appropriations to Indian Health Service require that alternative funding be accessed to the maximum extent possible.

Recently the South Dakota State Legislature extended a moratorium on licensure of long-term health care (nursing home) facilities. Because a state license is required as a preliminary condition of eligibility to receive reimbursement for services provided to eligible beneficiaries under Medicare/Medicaid, the Tribal Nations in this State have been effectively blocked from participating under Title XVIII and Title XIX of the Social Security Act.

Many of our Elders are being denied long-term health care and other elderly health care because this care is not available on the Reservation.
Most Indian elders are opposed to leaving their families to travel hundreds of miles to surrounding non-Indian communities for long-term health care but they must because this is not available locally.

Therefore, the Cheyenne River Sioux Tribal Nation strongly supports direct reimbursement of services provided to eligible beneficiaries of Medicare and Medicaid for long term health care, assisted living health care and other elderly health care. Direct reimbursement from HFCA to Indian Health Service and Tribes for long term health care, assisted living health care and other elderly health care programs under terms that waive all cost sharing for eligible beneficiaries served by Indian Health Service or Tribally managed long term health care facilities under Medicare, Medicaid or CHIP is critical to

ensure that Indian health programs have fair access to all Federal funding sources and the opportunity to modernize their programs to address the needs of and to fulfill the responsibility of the United States to Indian people.

Also, the Cheyenne River Sioux Tribal Nations support language that would permit Tribal Health programs to bill for and receive reimbursement for services provided to eligible beneficiaries under Medicare and Medicaid even when the facility in which these services are provided is owned by the Federal Government.

TITLE V - HEALTH SERVICES FOR URBAN INDIANS:

We appreciate and strongly support Congress' efforts to make quality health care available to Tribal members, who for whatever reason, choose to live in Urban areas. We favor language proposed to permit urban programs to receive lump sum payments for Indian Health Service contracts or grants under the title and to use carry-forward funding from one year to the next.

TITLE VI - ORGANIZATIONAL IMPROVEMENTS:

We urge Congress to act quickly to elevate the Director of Indian Health Service to an Assistant Secretary for Indian Health. With respect to the appointment of an Assistant Secretary for Indian Health appointed by the President with the advice and consent of the Senate, we support language that would require consultation with Tribal Governments prior to and during the appointment process with Tribal Governments being given the

opportunity to submit the names of qualified individuals, one of which will be selected by the President and the Senate.

TITLE VII - BEHAVIORAL HEALTH PROGRAMS

As we enter a new millenium it is heart-rending to be continually reminded of the "Grim Statistics in Indian Country"; e.g. Native American disease rates compared to all other races:

1. Alcoholism	**627% Greater**	**4. Accidents**	**204% Greater**
2. Tuberculosis	**533% Greater**	**5. Suicide**	**72% Greater**
3. Diabetes Mellitus	**249% Greater**	**6. Homicide**	**63% Greater**

While these overall statistics are alarming, more alarming still is the fact that the Aberdeen Area patients' health status is much worse than the average for the Indian Health Service as a whole due to the inequity inherent in the Indian Health Service distribution methodology which is primarily per capita driven.

These grim statistics continue to reflect the effect of cultural oppression, loss of traditions, a long history of forced internment on Reservations and a drastic change in lifestyle for our people; however, we feel it is time for us to join hands and resolve to improve upon the health status of the members of all Tribal Nations.

The aim of this title appears to attempt to integrate substance abuse, mental health and social services into wholistic behavioral health programs. The Cheyenne River Sioux Tribal Nation has consistently taken the leadership role in addressing the myriad of needs

associated with behavioral health problems; therefore, we strongly support integrating programs which are nurturing, fulfilling, accountable and responsible in offering significant opportunities for all Tribal Nations to enjoy wellness through a balance of modern medicine and traditional beliefs and treatments.

We urge Congress to provide adequate funding to begin to make significant measurable improvements in health status in the Aberdeen Area Indian health care.

TITLE VIII - MISCELLANEOUS

The Cheyenne River Sioux Tribal Nation strongly supports the establishment of a commission to study the questions which need to be resolved in defining entitlement and to making health care an entitlement as opposed to discretionary funding. As Treaty Tribes, we believe that health care is an entitlement by virtue of these treaty rights and as ratified by passage of the Snyder Act by Congress in 1921.

Of the twelve Indian Health Service areas, the Aberdeen Area IHS, comprised of North Dakota, South Dakota, Nebraska and Iowa, suffers from higher disease rates, and is under resourced to a greater extent than other areas. These factors combine to place an added burden on an already strained health delivery system.

Health care in this area is so inadequate that the life expectancy amongst tribal member is 6 years less than the IHS average and 12 years less than the national average. Diabetes is occurring at epidemic rates, even among juveniles. Amputations from diabetes complications are occurring at an alarming rate and Tuberculosis has once again become a threat to the lives of our members, largely because of lack of an adequate health facility

that is sufficiently staffed to provide daily patient care. This all points out the need for additional resources to improve health care in the Aberdeen Area.

Thank you for allowing the Cheyenne River Sioux Tribal Nation to express its opinion with regard to this important piece of legislation, its reauthorization and various amendments thereto. We urge Congress, as you consider this legislation, to consider the consequences to Indian people of continued under resourcing of our health programs.

P.O. Box 590
Eagle Butte, South Dakota 57625
(605) 964-4155
Fax:(605) 964-4151

TRIBAL MEMORANDUM

TO : SUPERINTENDENT, Cheyenne River Agency

FROM : Colette LeBeau Iron Hawk, Tribal Secretary DATE: 7/12/00

SUBJECT: RESOLUTION NO. 159-00-CR: Authorizes the submittal of a document entitled the "CHEYENNE RIVER TRIBAL NATION POSITION PAPER ON THE REAUTHORIZATION AND REVISIONS TO THE INDIAN HEALTH CARE IMPROVEMENT ACT," as our official comments relative to this proposed legislation.

Transmitted herewith are an original and two (2) copies of Resolution No. 159-00-CR, which was duly adopted by the Cheyenne River Sioux Tribal Council, during its Regular Session held on July 7, 2000.

CIH/wc
CC: Chairman
Treasurer
Administrative Officer
Council Representatives
District Officers
Central Records
Tribal Health Director
File/2

The blue represents the thunder clouds above the world where live the thunder birds who control the four winds. The rainbow is for the Cheyenne River Sioux people who are keepers of the Most Sacred Calf Pipe, a gift from the White Buffalo Calf Maiden. The eagle feathers at the edges of the rim of the world represent the spotted eagle who is the protector of all Lakota. The two pipes fused together are for unity. One pipe is for the Lakota, the other for all the other Indian Nations. The yellow hoops represent the Sacred Hoop, which shall not be broken. The Sacred Calf Pipe Bundle in red represents Wakan Tanka - The Great Mystery. All the colors of the Lakota are visible. The red, yellow, black and white represent the four major races. The blue is

RESOLUTION NO. 159-00-CR

WHEREAS, the Cheyenne River Sioux Tribe of South Dakota is an unincorporated Tribe of Indians, having accepted the provisions of the Act of June 18, 1934 (48 Stat. 984); and

WHEREAS, the Tribe, in order to establish its tribal organization; to conserve its tribal property; to develop its common resources; and to promote the general welfare of its people, has ordained and established a Constitution and By-Laws; and

WHEREAS, Congress is currently considering the Indian Health Care Improvement Act Reauthorization of 2000; and

WHEREAS, the Indian Health Care Improvement Act along with the Snyder Act is the core of the Federal Government's responsibility for meeting the health needs of all eligible Native Americans; and

WHEREAS, the Aberdeen Area Indian Health Service and tribally managed health programs are seriously under-resourced, causing our people to be afflicted by disease at rates much greater than other races and to suffer more and die much earlier than they should because they lack adequate health care; and

WHEREAS, it is important that we influence the Amendments to this Act to the greatest extent possible, to improve on health care throughout Indian Country; now

THEFORE BE IT RESOLVED, that the Cheyenne River Sioux Tribe does hereby authorize the submittal of a document entitled the "CHEYENNE RIVER TRIBAL NATION POSITION PAPER ON THE REAUTHORIZATION AND REVISIONS TO THE INDIAN HEALTH CARE IMPROVEMENT ACT," as our official comments relative to this proposed legislation.

RESOLUTION NO. 159-00-CR

Page Two

CERTIFICATION

I, the undersigned, as Secretary of the Cheyenne River Sioux Tribe, certify that the Tribal Council is composed of fifteen (15) members of whom 11, constituting a quorum, were present at a meeting duly and regularly called, noticed, convened and held this 7th day of July, 2000, Regular Session; and that the foregoing resolution was duly adopted at such meeting by an affirmative vote of 11 for, 0 against, 0 not voting and 4 absent.

Colette LeBeau Iron Hawk, Secretary

Cheyenne River Sioux Tribe

P.O. Box 590
Eagle Butte, South Dakota 57625
(605) 964-4155
Fax:(605) 964-4151

May 31, 2000

Mr. Lee Robinson, IHS
Division of Facilities and Environmental Engineering
12300 Twinbrook Parkway Suite 600 C
Rockville MD 20852

Mr. Robinson:

In response to your "Dear Tribal Leader" letter relative to "Supportable Space" and whether we should continue to "grandfather" certain facilities that exceed the allowable floor space.

We can not support your proposal to continue to provide additional funding to some facilities at the expense of others. This flies in the face of IHS' attempts to develop an equitable distribution formula for area budgets.

The primary concern here has to be equity. Any formula that permits some Tribes to receive a disproportionate share of funding must be discontinued in favor of a formula based on the same criteria for everyone.

Thank you for the opportunity to provide comment.

Sincerely,

Gregg Bourland, Chairman
Cheyenne River Sioux Tribe

The blue represents the thunder clouds above the world where live the thunder birds who control the four winds. The rainbow is for the Cheyenne River Sioux people who are keepers of the Most Sacred Calf Pipe, a gift from the White Buffalo Calf Maiden. The eagle feathers at the edges of the rim of the world represent the spotted eagle who is the protector of all Lakota. The two pipes fused together are for unity. One pipe is for the Lakota, the other for all the other Indian Nations. The yellow hoops represent the Sacred Hoop, which shall not be broken. The Sacred Calf Pipe Bundle in red represents Wakan Tanka - The Great Mystery. All the colors of the Lakota are visible. The red, yellow, black and white represent the four major races. The blue is

June 21, 2000

Dear

As Chairman of the Cheyenne River Sioux Tribal Nation, I have long been concerned with regard to the inadequate health care provided to the people of the Cheyenne River Reservation.

Our people continue to suffer from disease rates that are far in excess of those of the Nation as a whole and even exceed the rates of other areas of the Indian Health Service. Recently, this situation appears to have worsened, especially as it relates to in-patient care capabilities.

We strongly urge you to keep this in mind as you begin the task of deciding the future of our Tribal Nation's health care through the reauthorization of this important legislation.

We have attempted to address major issues that will have the greatest impact on our Tribal Nation's health status. Realize these comments are provided in all sense of fairness and sincerity and we trust you will consider them in that same regard.

We as a Tribal Nation stand ready to assist you any way we can to alleviate premature death and suffering amongst our people resulting from a failure by Congress to adequately fund Indian health programs.

If you should need additional information, please contact my office.

Sincerely,

Gregg J. Bourland, Chairman
Cheyenne River Sioux Tribe

CHEROKEE NATION
P.O. Box 948
Tahlequah, OK 74465-0948
918-456-0671

Chad "Corntassel" Smith
Principal Chief

Hastings Shade
Deputy Principal Chief

September 6, 2000

The Honorable Ben Nighthorse Campbell
United States Senate
Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Attn: Aurene Martin, Majority Senior Counsel

Dear Ms. Martin:

The following are responses to your letter dated August 28, 2000, regarding additional questions on S. 2526:

1. In this bill is a provision dealing with something termed a "quip." Could you explain what a quip is and how it works?

Section 203. Qualified Indian Health Program (QIHP)

QIHP creates a new provider type for Medicare and Medicaid (M/M) and any other federally funded health care program. It allows for tribes to obtain full cost recovery from M/M for all services provided. Specifically, if M/M reimburses any other provider for the services, it must reimburse the tribal health program the cost of providing the services. It eliminates the problems (with respect to tribes only) which arise from the lack of authority for Medicare to pay IHS for physician services. It also allows the tribe to collect the full indirect rate from M/M.

QIHP also allows for 100% pass-through on some items which are currently only treated as pass-through for some states. It significantly broadens the wrap around services which must be covered under M/M, including outstationing, preventive primary health care, immunizations, and other services which have historically not been reimbursable.

In summary, QIHP allows tribes to be reimbursed at the actual cost of the service provided, rather than the discounted rate that is based on shifting cost to private insurance, when there is little private insurance in Indian health.

2. Why are the provisions of Title IV so important to tribes and Indian health care in general?

As you are aware, Indian health care in general is dramatically underfunded, as referenced in the Level of Need Funded Study. With Medicare, Medicaid, Children's Health Insurance Program, and private insurance currently only paying approximately 10% of all Indian health care services, all additional sources of revenue will benefit Indian people. Title IV would increase the percentage paid by these revenue sources only slightly, but any increase for Indian health care would enable tribes to provide care to even a few more tribal members.

3. You stated in your testimony that the Cherokee Nation operates six outpatient clinics that provide services to Medicare-eligible recipients, but is not able to get reimbursement from Medicare for those services. Could a non-Indian or non-IHS facility receive Medicare reimbursements for providing these same services?

Yes, a non-Indian facility could receive Medicare reimbursement if the individual has Medicare Part B. Most patients don't have Medicare Part B (which pays for outpatient services) so they utilize the Indian health care system instead of non-Indian health care facilities. Also, the Indian health care system receives 20% less than the non-Indian health care facilities because we don't receive the co-pay. Unless a tribally-operated clinic becomes a Rural Health Center, a Federally Qualified Health Center, or a Facility of the Service it cannot bill Medicare. This has become more problematic due to the phasing out of the full-cost reimbursements for Federally Qualified Health Centers.

4. As a tribal representative, can you tell me what you view as the most serious health problems facing Indian people in the immediate, medium, and long-terms?

As reflected in various data and numerous studies, diabetes and related conditions, such as heart disease, high blood pressure, and high cholesterol are the most serious health problem facing Indian people today. The complications of diabetes include amputations and blindness which render many American Indian's disabled. This is an immediate need that has not been adequately addressed.

Congress appropriated $30 million for 5 years to address this problem. However, as we are entering our 4th year, it is just not enough money to make a big difference in the diabetes epidemic. The Cherokee Nation received $1.37 million from the IHS Diabetes Grant Program for a 12-month period. One of the purposes of the 5-year Diabetes Grant program is to engage in tribally-directed prevention programs. However, the entire budget could be spent on drugs to treat people with diabetes, leaving no funding for other activities, such as nursing staff for diabetes clinics, orthotics, surgery, information systems, training and prevention.

Here at Cherokee Nation, unless we receive additional funding for diabetes, our entire Diabetes Grant could be consumed by paying for prescription drugs. There are three reasons for this: 1) the number of people diagnosed with diabetes is growing; 2) there are new and more effective drugs available to treat people with diabetes and they cost more than the older drugs; and 3) the IHS funding has not kept pace with the rising cost of pharmaceuticals.

Other serious health problems facing Indian people include cancer, alcoholism and other substance abuse related diseases, and serious and chronic mental illness, often resulting in suicide. A long-term health problem is disabilities from diabetes and from injuries due to alcohol-related events. Other long term health problems result from child abuse and domestic violence.

5. You stated approximately half of the enrolled tribal members in the U.S. live off the reservation. How many of these people live in urban areas? Do you support the IHS efforts to provide services for these tribal members in the Oklahoma City and Tulsa Urban Indian Health Centers?

Approximately 75-80% of the tribal members who live off the Cherokee Nation reservation live in urban areas.

Oklahoma City and Tulsa urban programs were designated as demonstration sites in the FY'87 Interior Appropriations Act. Since then, Congress provided further clarification on how the Oklahoma Demonstration Projects should be treated in the 1992 amendments to the IHCIA. The entire state of Oklahoma was designated a Contract Health Service Delivery Area (CHSDA) and urban Indian populations were included in the Oklahoma Area's calculation of IHS eligible patients.

P.L. 94-437, Section 512, passed in 1992, states that the "Oklahoma City Clinic demonstration project and the Tulsa Clinic demonstration project shall be treated as service units in the allocation of resources and coordination of care and shall not be subject to the provisions of the Indian Self-Determination Act for the term of such projects." This section also states that a report will be submitted to Congress for fiscal year 1999, which will include findings and conclusions.

The Tulsa Urban Indian Clinic is a beautiful and efficient clinic that serves the urban Indian people well. The clinic serves 140 tribes; with 45% being Cherokee and 26% being Creek. The clinic is the only urban program that is located within a tribal jurisdictional area.

Both Oklahoma demonstration projects are considered urban programs as well as service units. The ramifications of giving permanent status to these demonstration projects and

them retaining their Title V status as service units needs to be analyzed by the two tribes in this area.

The requirement for a report on this demonstration project should include a full analysis by the two tribes. Information is needed to determine the extent to which tribal funding is being used to support urban clinics in Oklahoma, and the sovereignty issues associated with tribal contracting and compacting of these service units.

The Cherokee Nation endorses the concept of federal funding for urban Indian clinics. However, the entire Indian health system requires adequate funding so that we are not competing for limited resources. With Oklahoma being the lowest funded area in the country, it is hard for us to endorse funding for other programs until the Level of Need Funded formula is implemented.

Thank you for this opportunity. If you need any further information, please feel free to contact me.

Sincerely,

Melissa McNiel
Executive Officer
Office of Principal Chief